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CHILDREN'S MENTAL HEALTH: PROMISING RESPONSES TO NEGLECTED PROBLEMS

HEARING

BEFORE THE

SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, JULY 14, 1987

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CHILDREN'S MENTAL HEALTH: PROMISING RESPONSES TO NEGLECTED PROBLEMS

TUESDAY, JULY 14, 1987

House of Representatives,
Select Committee on Children, Youth, and Families,
Washington, DC.

The Select Committee met, pursuant to call, at 9:05 a.m., in room 2261, Rayburn House Office Building, Hon. George Miller (chairman of the Select Committee) presiding.

Members present: Representatives Miller, Boggs, Durbin, Skaggs, Coats, Hastert, and Holloway.

Staff present: Ann Rosewater, staff director; Anthony Jackson, professional staff; Lisa Naftaly, research assistant; Ellen O'Connell, secretary; Mark Souder, minority staff director; and Carol Statuto, minority deputy staff director.

Chairman Miller. The Select Committee on Children, Youth, and Families will come to order.

Today, the Select Committee will examine the significant yet often unspoken concern: children's mental health. Emotionally troubled children are not unfamiliar to any of us. These are the children who are too aggressive or too withdrawn, who have problems learning in school, or who will get into trouble with the law. Yet what is relatively new is the recognition that these problems often are, in fact, mental health problems and not simply the passing problems of childhood. And what is even newer is that emotional problems can beset even infants and toddlers.

For too long, children's emotional problems have been so stigmatized that many parents have not sought the help their children need, and when they have sought help, most often it was not available. Yet, left untreated, these problems can not only devastate a child's life, but also unravel the fabric of the entire family.

A recent study by the Office of Technology Assessment found that as many as 15 percent of America's children, up to 9.5 million, suffer mental health problems warranting treatment, yet it also found that 70 to 80 percent of them receive either inappropriate care or no care at all.

A great deal remains to be learned about how to treat troubled children. Meanwhile, children are falling through the cracks because appropriate care is unavailable in some communities, uncoordinated in others, and unaffordable by many families across the country.

Without community-based care, mentally ill children are unnecessarily taken from their homes, hospitalized or institutionalized;

and, in some cases, families are forced to give up custody of their children to get treatment at all. Children get bumped from agency to agency, from group home to foster home, further exacerbating their mental illness.

Our Government has accepted no obligation to ensure that children with mental health problems receive the care they need, and our progress in improving mental health care for children during this decade has been modest at best.

Legal protections to help emotionally impaired children have not been given the resources to make them fully effective. For example, the Education For All Handicapped Children Act entitles emotionally impaired children to an appropriate education in the least restrictive setting, yet the lack of mental health services often prevents these youngsters from realizing the promise of the law.

In California, early pioneering efforts to improve mental health care were thwarted by a wholesale dumping of the mentally ill from State institutions without providing community-based services. Since then, it has taken nearly a decade for the State to implement Public Law 94-142 for emotionally disturbed children.

Three years ago, the State enacted a law to ensure that every special education student suffering emotional problems receives a comprehensive evaluation by county mental health personnel, as well as appropriate treatment. But despite $15 million in start-up funding in the past two years, the magnitude of the referrals coming into the mental health system greatly outdistances the funds available.

County mental health departments, like the one in my home district, Contra Costa County, have been overwhelmed by a rapid increase in the number of children with severe mental health problems, particularly violent children from families torn apart by economic pressures or disintegrated because of drug and alcohol problems.

The overloaded mental health system can only provide triage, not treatment. Mental health resources are being channeled toward the most self-destructive youth, leaving little for quieter crises that then go untreated. Waiting lists in county mental health clinics number in the hundreds. Many of these children are removed from home, and when no appropriate placement can be found, some end up on inpatient psychiatric wards for adults. This practice, once a drastic temporary alternative, is now common.

Today we will learn about the prevalence of mental illness among children, barriers to effective treatment, and innovative responses that are effective in helping children and families.

I welcome all of our witnesses here today. I am especially pleased that Stuart McCullough, director of the Department of Mental Health in Contra Costa County, has traveled from California to share with us the disturbing problems of mentally ill children in our community and the model public/private efforts that the county has undertaken to support these troubled families.

OPENING STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

Today, the Select Committee on Children, Youth and Families will examine a significant yet often unspoken concern: Childrens mental health.

Emotionally troubled children are not unfamiliar to any of us. These are the children who are too aggressive or too withdrawn, who have problems learning in school, or who get into trouble with the law. Yet what is relatively new is the recognition that these problems often are, in fact, mental health problems and not simply the passing problems of childhood. And what is even newer is that emotional problems can beset even infants and toddlers.

For too long, children's emotional problems have been so stigmatized that many parents have not sought the help their children need. When they have sought help, most often it has not been available. Yet left untreated, these problems can not only devastate children's lives, but also unravel the fabric of the entire family.

A recent study by the Office of Technology Assessment found that as many as 15 percent of American children—up to 9.5 million—suffer mental health problems warranting treatment. Yet it found that 70–80 percent of them receive either inappropriate care or no care at all.

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Despite these recent efforts, county mental health departments like the one in my home district, Contra Costa County, have been overwhelmed by a rapid increase in the number of children with severe mental health problems, particularly violent children from families torn apart by economic pressures, or disintegrated because of drug and alcohol abuse.

The overloaded mental health system can only provide triage, not treatment. Mental health resources are being channeled toward the most self-destructive youth, leaving little for quieter crises that then go untreated. Waiting lists at county mental clinics number in the hundreds. Many of these children are removed from home, and when no appropriate placement can be found, some end up on inpatient psychiatric wards for adults. This practice, once a drastic temporary alternative, is now common.

Today we will learn about the prevalence of mental illness among children, barriers to effective treatment, and innovative responses that are effective in helping children and families.

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CHILDREN'S MENTAL HEALTH: PROMISING RESPONSES TO NEGLECTED PROBLEMS—A FACT SHEET

MILLIONS OF CHILDREN SUFFER FROM MENTAL HEALTH PROBLEMS

From 7.5 to 9.5 million children in the U.S.—12 to 15% of those under 18—suffer from a mental health problem severe enough to require treatment. (Office of Technology Assessment [OTA], 1986)

During the 1985-86 school year, 376,943 emotionally disturbed children aged 3-21—less than 1% of the total school population—received services under the Education of the Handicapped Act. (U.S. Department of Education, 1987)

Seventy to 90% of runaway and homeless youth in the New York City area have emotional problems. Thirty percent are depressed or suicidal; 18% are antisocial; and 41% are a combination of these. Fifty percent of the children have been abused by their parents. (Shaffer, 1984)

The most common childhood psychiatric disorders include: depression (between 5-10% of youth, with a threefold increase in the frequency of depression from childhood to adolescence) (National Institute of Mental Health [NIMH], 1987); conduct disorder (about 4-10% of youth; prevalence appears to be at least three times more common among boys than girls) (Melton, 1987); eating disorders (an estimated 1% of high school and 3% of college age women are anorexic; 5-10% of that population are bulimic) (NIMH, 1987); attention deficit disorder/hyperactivity (an estimated 3-5% of the school-age population) (NIMH, 1987); autism (about 5 out of 10,000 children; an additional 10 out of 10,000 children have related behavioral problems) [NIMH, 1987]; psychosis (an estimated 0.23% of youth) (Gillmore, Chang, & Coron, 1983 cited in Melton, 1987); suicide (nearly 1,900 teenagers, aged 12-19, took their own lives in 1984.) (Select Committee on Children, Youth and Families, 1987).

SERVICES FOR CHILDREN WITH MENTAL HEALTH PROBLEMS LARGELY UNAVAILABLE

An estimated 70-80% of emotionally disturbed children get inappropriate mental health services or no services at all. (OTA, 1986)

Less than 1%, or 100,000 children, receive mental health treatment in a hospital or residential treatment center in a given year, and perhaps only 5%, or 2 million children, receive mental health treatment in outpatient settings. (OTA, 1986)

Shortages exist in all forms of children's mental health care, but there is a particular shortage of community-based care, case management, and coordination across educational, judicial and other child serving agencies. (OTA, 1986)

Nationwide, there was a 13.5% shortage of special education teachers for the emotionally disturbed during the 1984-85 school year. (U.S. Department of Education, 1987)

THOUSANDS OF CHILDREN PLACED IN RESTRICTIVE SETTINGS, OFTEN INAPPROPRIATELY

A 1980 survey of one-third of the nation's public and private hospitals found an estimated 81,532 persons under age 18 were admitted to inpatient psychiatric units. Approximately 95% of these children and youth were between the ages of 10 and 17, 53% were males, and 82% were white. (Jackson-Beeck, Schwartz & Rutherford, in press)

A 1983-84 National Inventory of Mental Health Organizations estimates that about 26% of patients under 18 were served in private psychiatric hospitals, while 5.8% were served in State and county mental hospitals. (NIMH, 1986)

State hospitals absorb about 70% of state mental health dollars. (Frank & Hamlet, 1985)

Studies suggest that at least 40% of the hospital placements of children are inappropriate. Either the children should never have been admitted to the institutions or they have remained too long. (Knitzer, 1982)

Juveniles tend to be admitted for less serious and less precise mental health and drug/alcohol disorders than adults, and their average length of stay is twice as long. For example, in 1985, the average length of stay for juveniles admitted for neurotic disorders was 23 days, as compared to less than 11 days for adults with the same diagnosis; and the average length of stay for juveniles admitted for nondependent use of drugs and alcohol was 23.4 days, as compared to 12.5 days for adults with this diagnosis. (Jackson-Beeck, et al., in press)

Despite a decline in the population of 10-to-17 year olds in the Minneapolis/St. Paul Metropolitan Area of Minnesota, admissions of juveniles to hospital psychiatric units increased 25% between 1977 and 1985. This increase may not reflect any increase in the numbers of teenagers with psychiatric problems, but rather a means of dealing with "problem" youngsters. (Jackson-Beeck, et al., in press)

WHITE, MINORITY CHILDREN TREATED IN DIFFERENT SETTINGS

Non-white youth are twice as likely to be hospitalized in state and county hospitals as white youth. (Truitt, 1985)

In a three-state survey of residential treatment, over 70% of youth in "health" facilities were white, while the majority of youth in "justice" centers were from minority groups. About half of youth in public facilities but only ¼ of youth in private centers were nonwhite. (Government Accounting Office [GAO], 1985; Krisberg, Schwartz, Litsky, & Austin, 1986)

Of 824 Florida youngsters in residential placements in 1984, 50% of those in Florida training schools and 33% of those in the adolescent units at the state hospital were black; in contrast only about 20% of the children in the other placement sites were black. (Friedman Kutash, 1986)

MENTAL HEALTH CARE FOR CHILDREN INCREASINGLY FOR PROFIT

In 1966, 7.6% of the 145 psychiatric facilities for children and youth in the U.S. were operated for profit; by 1981, 17.1% of 369 facilities were operated for profit—a 125% increase. (Office of Juvenile Justice and Delinquency Prevention, 1983)

Between 1980 and 1984, admissions of adolescents to private psychiatric hospitals increased an estimated 450%—rising from 10,764 to 48,375. (National Association of Private Psychiatric Hospitals, 1985)

A survey of state certificate-of-need agencies showed that proprietary interests now account for about ⅔ of applications for child and adolescent mental health/substance abuse programs. (Scalora & Melton, in press)

FEDERAL SUPPORT FOR TROUBLED YOUTH LIMITED

In fiscal year 1987, $509 million was appropriated for the Alcohol, Drug Abuse and Mental Health Block Grant [ADMBG], of which approximately 50 percent went to mental health services. In 1985 a 10 percent set aside for new mental health services for severely disturbed childern and adolescents was amended to include underserved populations, such as the homeless and the elderly, diminishing the focus on children. A GAO survey of 13 states found that some states chose not to fund children's services at all with the 1985 set aside. (Congressional Research Service [CRS], 1987; GAO, 1985 cited in OTA, 1986)

Since the Community Mental Health Centers Act was repealed in 1981 and folded into the ADMBG, funding for mental health services has dropped from $277.6 million in FY81 to $248 million in FY87. (CRS, March 1987)

In FY85, 20.9 percent ($49.6 million) of NIMH's budget was spent on children and youth-related activities. (NIMH, 12th Annual Report on Child and Youth Activities, FY85)

NIMH's clinical training program has been cut 85 percent over the past seven years—from $70 million in 1980 to $15 million in 1987. Of that $15 million, only $3.3 million is used for training child mental health professionals. (American Academy of Child and Adolescent Psychiatry, May 1987)

Although NIMH commits approximately 20 percent of its current research budget to children's issues, available dollars have not kept pace with assessments of the funds necessary. (OTA, 1986)

In FY86, the Federal Child and Adolescent Service System Program (CASSP) spent $4.7 million to help 28 States and 3 localities develop a comprehensive,, integrated system of care for emotionally disturbed children and adolescents. (NIMH, 1987)

COST-EFFECTIVE PROGRAMS IMPROVE CHILDREN'S MENTAL HEALTH CARE DELIVERY

Between 1981 and 1986, Florida's multi-agency network for severely emotionally disturbed students, SEDNET, reduced both out-of-state and out-of-region placement by 50 percent despite a 28 percent increase in identified youth. (Clark, 1987)

Ventura County Mental Health Demonstration Project, which provides an interagency system of care for the most needy children, has reduced state hositalization by 25 percent, saving an average of $428,000 annually, reduced out-of-county, court-ordered treatment placements by 46 percent, reduced re-incarcerations by 47 percent and has saved the state millions of dollars. (Ventura County Children's Mental Health Project, 1987)

Chairman MILLER. I would like to say that I understand Congressman Coats is on his way, but because of the time problems in the usage of this room I would like to go ahead and call the first panel. That panel is made up of Glenda Fine, who is a parent and director of Parents Involved Network, from Philadelphia. Jean Gaunt, who is a foster parent from Indianapolis, Indiana; Dr. Leonard Saxe, who is the principal author of the Office of Technology Assessment Report on Children's Mental Health; Dr. Jane Knitzer, who is the director of the Division of Research, Development, and Policy, and senior policy scientist at Bank Street College of Education in New York; and Dr. Robert Friedman, who is the director of the Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children, Florida Mental Health Institute, University of South Florida. If they would come forward, please.

We will recognize you in the order in which I called your name. Let me just say, without disturbing the integrity of your statements, the extent to which you can summarize would be appreciated, because I want to make sure that we leave enough time for discussion and for answers.

So welcome to the committee, and thank you very much for your time and your effort to get here and also for the help that you have already provided the committee.

Glenda, we will start with you.

STATEMENT OF GLENDA FINE, DIRECTOR, PARENTS INVOLVED NETWORK PROJECT, MENTAL HEALTH ASSOCIATION OF SOUTHEASTERN PENNSYLVANIA, PHILADELPHIA, PA

Ms. FINE. Mr. Chairman, members of the committee, my name is Glenda Fine, and I have a 16-year-old son who has serious emotional problems. I am also director of the Parents Involved Network Project in Philadelphia sponsored by the Mental Health Association of Southeastern Pennsylvania. Parents Involved Network's primary goals are to organize self-help advocacy groups for parents of children and adolescents who have severe emotional disturbances and to train parents to become effective advocates for their children.

I want to tell you about the serious problems I and other parents like me across the country have encountered in trying to obtain services for our children.

The mental health needs and problems of children are diverse in nature and intensity. Some children have disorders that respond to intervention, diagnosis, treatment, and services. Others with more serious, complex disorders and needs often find their tragic plight exacerbated by inadequate service systems. We struggle to become our child's advocate, often learning how to make the system respond by a trial and error process. We become overwhelmed, frustrated, confused, and emotionally drained by the process. Many of us give up.

While some very promising changes are occurring throughout the country in response to the mental health needs of children, it is important for you to know that the range of services are frequently unavailable, that there is very little coordination among the systems that are mandated to serve our children, and there is usually no plan to determine which agencies should be responsible for serving a particular child. This evasion of responsibility results in long delays in providing children with desperately needed services. Consequently, our children are unserved, underserved, or served inappropriately.

To illustrate, I would like to relate some of my personal experiences. When my son Joshua was two years old, I kept thinking to myself that he was not like other children and that something was wrong. During this time, our second son was born, and five months later my husband died. Joshua retreated into his own little world, missing his father and confused because his mother was not happy and smiling any more. Joshua stopped talking except for an occasional whisper of, "Where's my daddy?" He wrapped himself in a cocoon because life was just too painful. I still remember weeping night after night for my husband and for my little boy who was in such distress. I did not know what to do for him; I did not know where to go or how to get help.

My family urged me to have Joshua evaluated by a child psychiatrist. As a result of the evaluation, Joshua was diagnosed as having a very severe childhood depression and autistic tendencies. I was told that his speech would eventually return but that I could look forward to a child who would display serious emotional problems. Time passed, and I did the best I could to establish a warm and nurturing environment.

Joshua was five when he entered kindergarten, and this was a complete disaster. He was evaluated by the school district psychologist and diagnosed as hyperactive and learning disabled this time. From the time of my husband's death until kindergarten, Joshua was seen by various psychiatrists, and each one tried a different approach and gave a different diagnosis.

At the time of the school evaluation, I could no longer afford private treatment, and I then turned to my county mental health system. My first experience was devastating, as I was told that I was the cause of my son's problems, and that I needed to be in treatment, and that he was perfectly okay. I was incredulous that a mental health professional could make this statement after meeting with me, not with my son, for approximately 45 minutes. I went to another community mental health center and was put on a long waiting list. The phone never rang.

The following years were filled with disjointed and desperate attempts to find help for my son. When Joshua was 10, he was hospitalized because of his destructive behavior to himself and to our home. The diagnosis was that he was seriously emotionally disturbed, and he was recommended for a partial hospitalization program, but there were no openings!

When Joshua was 12, our home life was so chaotic that I feared for my sanity and for the emotional stability of my other son. We stumbled through daily living with the help, finally, of an excellent therapist at a community mental health center. When Mr. Green left eight months later for another position, we were once again put on a waiting list.

When Joshua was 13, I approached our county children and youth agency asking for any specialized support services they might have available. There was nothing, no respite, no in-home services, nothing.

Mr. Chairman and members of the committee, it was at this time that I would have sold my soul for the money to send my son to a private boarding school with a therapeutic environment for children with serious emotional problems. I had come to the realization that I could not provide the structure and supports that my son so desperately needed.

My next step was to ask the county office of mental health for some type of residential treatment for Joshua. He was evaluated, and again we had the same diagnosis. The treatment recommended was a therapeutic structured environment in a residential placement.

I was told that the county mental health system did not provide this service and I would have to turn to the child welfare system. In order for Joshua to be placed in a residential facility, I would have to give the state custody of my child. My 12-year nightmare had led me to this indignity and humiliation. The state, by assuming custody of my son, had indicted me. I had not abused or neglected my child. On the contrary, I had used every bit of my energy and wherewithal in a desperate search for help for Joshua. He now had to be adjudicated dependent because—and I quote—"he was without proper parental care or control." This injustice, all too commonplace, is a grave indictment of our mental health system.

Another family story highlights the problems parents experience with the public education system. Richard is six years old and has serious emotional problems. Five weeks after entering first grade, his parents were told that he could not return to school. Richard had been talking about suicide in school, and the school district did not feel that they could provide an appropriate program for him. He was hospitalized, and, on discharge, the parents were told that the staff was baffled and diagnosed Richard as hyperactive with mild brain damage. The school district refused to take Richard back and recommended home-bound instruction. Is this the best that our society has to offer a six-year-old troubled boy?

The Education of the Handicapped Act was passed by Congress to end such exclusion of disabled children from public schools and to ensure that all handicapped youngsters receive appropriate special education programs from their local school districts. Yet, as Richard's story tells us, more often than with any other category, children with serious emotional problems are excluded from public school programs or are limited to a few hours of home-bound instruction each week.

To summarize, our troubled children are the casualties of systems that do not work or, at best, fall short of addressing their complex needs. There is no public mandate for our children's mental health needs.

We believe that our first-hand experiences and perspectives as parents of children with severe emotional problems could do much to inform legislative policy deliberations and choices about priorities for our children. Representatives from the Parents Involved Network would certainly be willing to participate in any forum you deem appropriate for that purpose.

Again, I urge you to listen to parents. We have lived with our children, we have information and insight, and we are your best untapped resource.

Thank you.

[Prepared statement of Glenda Fine follows:]

PREPARED STATEMENT OF GLENDA FINE, DIRECTOR OF THE PARENTS INVOLVED NETWORK PROJECT, MENTAL HEALTH ASSOCIATION OF SOUTHEASTERN PENNSYLVANIA, PHILADELPHIA, PA

Mr. Chairman, members of the committee. My name is Glenda Fine and I have a 16-year old son who has serious emotional problems. I am also Director of the Parents Involved Network Project in Philadelphia sponsored by the Mental Health Association of Southeastern Pennsylvania. Parents Involved Network's primary goals are to organize self-help/advocacy groups for parents of children and adolescents who have severe emotional disturbances. Historically parents of these children have not joined together as have parents of children with other disabling handicaps. Stigma, parental blame and isolation are but a few of the reasons this has not happened.

I want to tell you about the serious problems I and other parents like me across the country have encountered in trying to obtain services for our young children.

The mental health needs and problems of children are diverse in nature and intensity. Some children have disorders that respond to intervention, diagnosis, treatment and services. Others, with more complex disorders and needs, often find their tragic plight exacerbated by inadequate service systems.

We struggle to become our child's advocate--often learning how to make the system respond by a trial-and-error process. We become overwhelmed, frustrated, confused and emotionally drained by the process. Many give up!

While some very promising changes are occuring throughout the country in response to the mental health needs of children,it is important for you to know that the range of services are frequently unavailable; that there is very little coordination among the systems that are mandated to serve our children and there is usually no plan to determine which agency should be responsible for serving a particular child. This evasion of responsibility results in long delays in providing children with desperately needed services. Consequently, children are unserved, underserved or served inappropriately.

When my son was two years old I kept thinking to myself that he was not like other children and that "something was wrong". My husband and our pediatrician felt that I was an overanxious parent of a first child. However, they did agree that Joshua was hyperactive and a very difficult child to manage. During this time our second son was born and five months later my husband died suddenly. Joshua retreated into his own little world, missing his father, confused because his mother was not smiling and happy anymore and occasionally physically attacking his sibling. Joshua stopped talking except for an occasional whisper of "where's my daddy". He wrapped himself in a cocoon because life was just too painful. I still remember weeping night after night for my husband and for my little boy who was in such distress. I did not know what to do for him, where to go or how to get help. My family urged me to have Joshua evaluated by a child psychiatrist. As a result of the evaluation Joshua was diagnosed as having a severe childhood depression as well as hyperactivity and autistic tendencies. I was told that his speech would eventually return but that I could look forward to a child who would display serious emotional problems.

Time passed and I did the best I could to establish a warm and nurturing home environment.

At age five Joshua entered kindergarten and this was a disaster. He was evaluated by the school district and diagnosed as hyperactive and learning disabled. From the time of my husband's death until kindergarten Joshua was seen by various psychiatrists and each one tried a different treatment approach and gave a different diagnosis. At the time of the school evaluation, I could no longer afford private treatment and I then turned to the county mental health system.

My first experience was devastating as I was told that I was the cause of my son's problems and that I needed to be in treatment and that he was perfectly ok! I was incredulous that a professional could make this statement after meeting with me (not with Joshua) for approximately 45 minutes. I went to another community mental health center and was put on a long waiting list. The phone never rang.

The following years were filled with disjointed and desperate attempts to find help for my son.

When Joshua was ten he was hospitalized because of his destructive behavior to himself and our home. The diagnosis was seriously emotionally disturbed and he was recommended for a partial hospitalization program. There were no openings!

When Joshua was 12 our home life was so chaotic and life was like waiting for a time bomb to explode. I feared for my sanity and for the emotional stability of my other son. We stumbled through daily living with the help, finally, of an excellent therapist at a community mental health center. When Mr. Green left 8 months later for another position we were once again put on another waiting list.

When Joshua was 13½ I approached our county children and youth agency asking for any specialized support services they might have available. There was nothing! No respite, no in-home services,...nothing.

Mr. Chairman and members of the committee..it was at this time that I would have sold my soul for the money to send my son to a private boarding school with a therapeutic environment for seriously emotionally disturbed children.

I came to the realization that I could not provide the care and supports that my son so desperately needed. My next step was to ask the county children and youth agency for some type of residential treatment facility for Joshua. Joshua was evaluated with the same diagnosis. The treatment recommended was a therapeutic structured environment in a residential placement. I was told that the county mental health system did not provide this service and I would have to turn to the child welfare dependency system. In order for Joshua to be placed in a residential facility it was necessary for me to give the state custody of my child.

My 12 year nightmare had led me to this indignity and humiliation. The state by assuming custody of my son had indicted me. I had not abused or neglected my child. On the contrary, I had used every bit of my energy and where-with-all in a desperate search for help for Joshua. He now had to be adjudicated dependent because, and I quote, "he was without proper parental care or control". This injustice, all too commonplace, is a grave indictment of our mental health system.

Another family's story highlights the problems parents experience with the public education system.

Richard is 6 years old and is seriously emotionally disturbed. Five weeks after entering first grade his parents were told he could not return to school. Richard had been talking about suicide and the school district did not feel they could provide an appropriate program for him. He was hospitalized and on discharge the parents were told that the staff were baffled and diagnosed Richard as hyperactive with very mild brain damage.

The school district refused to take Richard back and recommended homebound instruction. Is this the best that our society has to offer a 6 year old troubled boy?

The Education of the Handicapped Act was passed by Congress to end such exclusion of disabled children from public schools and to insure that all handicapped youngsters receive appropriate special education programs from their local school districts.

Yet as Richard's story tells us, more often than with any other category of disabled children, seriously emotionally disturbed children are excluded from public school programs or are limited to a few hours of homebound instruction each week.

To summarize, our troubled children are the casualties of systems that do not work or at best fall short of addressing their complex needs. In your efforts to legislate and fund better systems of care I urge you to listen to parents. We have lived with our children -- we have information and insight -- we are your best untapped resource!

Thank you.

Chairman MILLER. Ms. Gaunt.

STATEMENT OF JEAN GAUNT, FOSTER PARENT, INDIANAPOLIS, IN

Ms. GAUNT. Thank you.

Mr. Chairman and members of the committee, my name is Jean Gaunt, and I am the mother of an adopted child who suffers from some emotional problems, as well as a foster mother who has cared for children suffering from emotional problems. I would like to share my son Jason's story with you.

Jason was removed from his birth home for severe abuse and neglect at age three. Between the ages of three and six, Jason was placed in 10 placements, 8 foster homes, and 2 failed adoptions. At age six, Jason was diagnosed by two therapists with differing views. At age six, he was also placed into my foster home. At age seven, a pediatrician misdiagnosed Jason. At age eight, a neurologist wouldn't recommend referral to the children's hospital in Indianapolis. At age eight, the school labeled Jason as emotionally handicapped. His therapist said he had learning disabilities.

Our family moved a number of times to get services for Jason when he was eight and nine. At eight, we finalized the adoption. At age nine, Jason was tested and placed as learning disabled at school. At age nine, Jason was referred by another pediatrician to the school's hospital, where this time he was tested, diagnosed, and treated, and the doctor said that Jason was hyperactive.

We have continued with Jason's therapist for his entire placement even though the therapist has moved twice as well. We have experienced problems with the system. For example, Jason wandered around, was found by the police, and was placed in an emergency shelter. Therapists for Jason feel Jason is not hyperactive but is displaying strong tendencies of an emotionally handicapped child. Jason will be ten years old next month. His therapist says we can only wait to see what happens.

Please turn to pages 12 and 13 of my report on Ricky. Ricky is another example of a foster child who was adopted. Ricky was removed from his birth home for abuse and neglect at age four. No services were provided for his birth home. Ricky bounced from four foster homes, five temporary shelters, and three failed adoptive placements from age four to ten. At age 10, he received his first counseling until the age of 12. Therapists felt he was mentally delayed. Ricky's adoption in his fourth home was finalized. At age 12, therapists diagnosed Ricky was depressed. The adoptive mother said no appropriate intervention was offered to him or their family.

At age 12, Ricky attempted to molest his physically disabled sister and one other and left home for seven institutional placements, two residential placements, and two emergency shelter placements, including some of out of State, in order to get a therapeutic setting. One of the institutions at age 12 implied Ricky had a character disorder but advised the parents not to share it in order for them to find a placement for Ricky, as all facilities he was aware of did not take children with character disorders because they didn't provide a therapeutic setting in our state.

At age 12, Ricky was adjudicated in order for his parents to get services for Ricky. During ages 12 to 18, three institutions diagnosed Ricky as having a character disorder and sociopathic tendencies. Some found him untreatable. Reports from one said Ricky saw himself as beyond the law. Tomorrow, Ricky will be officially released as a ward of the court, and his service has been nil.

I see many parallels between Jason's and Ricky's lives. By the way, last week we found burnt matches and paper in our basement from our son. Yet I feel encouraged, and things are improving for these emotionally handicapped children through some programs that I have heard about. First of all, Jason was one of the first special needs adoptions, which helped with some of our medical expenses. Also, I have just recently become aware of a new program called CASSP. This program gives me great hope that something can be done through teamwork.

I was also present at a Families As Allies conference last month where birth parents from nine states gathered with professionals to share ideas on defining and breaking down barriers as they saw them for the emotionally handicapped children.

Indiana listed their barriers as the following: number one, unstable and inadequate resources for severely emotionally disturbed children; number two, lack of advocacy efforts; three, lack of coordination and cooperation among Government agencies; four, unwillingness of service providers to tolerate advocacy and the institutional refusal to be accountable; five, lack of parental support groups; six, difficulty in assessing care; and, seven, lack of parental, public, and professional awareness of the needs and the rights of the severely emotionally disabled.

As a parent and foster parent, I developed a Rairden Resource Center for Foster Care to assist foster parents to locate services, including those for the emotionally handicapped children in the Indianapolis area. I also advocate for Federal regulation of the number of children in caseloads of a caseworker across the nation.

I feel encouraged in my state because my state is willing to include its foster parents as team members to improve training in the near future, to care for children with emotional problems, as well as to be supportive to foster parent associations, which provide support for parents of these children.

Thank you very much.

[Prepared statement of Jean May Gaunt follows:]

PREPARED STATEMENT OF JEAN MAY GAUNT, FOSTER PARENT, INDIANAPOLIS, IN

I want to thank the members of this committee for the opportunity to share with you as a foster parent. I have seen many things that as a regular parent I would not have had the opportunity. While we in this country are consumed with the issues of AIDS and Oliver North because they are issues that seem immediate and pressing. I have witnessed over these last fourteen years an urgency that has been hidden in society. The other day my daughter said to me "Mom? Why are you a foster parent?" When I became a foster parent I told everybody that it was to save children, but when my daughter asked me that question, I had to stop and re-examine why I was a foster parent. I am not a foster parent to save the child today. Yes I am, but its more than just that. It's also to save families. Families are in crisis as never before. Family units are eroding to the point that irreversable damage is being done to our children. What frightens me most is that we are not taking care of the problem, we are ignoring it, and as a result we have children like Ricky. I suggest that you take a long look at the material I've included about Ricky in a fact sheet at the end of this report. It represents a time line of his entering the system and the dollars and time spent on Ricky.

How many children should go through twenty-seven placements? It seems extraordinary does'nt it? It is not, though. Ricky represents or is more typical than we would like to believe.

Be it Michele or Donny or Jesse or even Jason, my own adopted son, in foster care they are becoming more the rule than the exception.

Their families have been filed upon. They have not been serviced. They have not been treated with dignity. They have not received the adequate help they desperately need to remain intact as a family. We have taken these children out of the birth homes, thrown them in foster homes and in much of the nation there is not enough adequate training for the foster homes. It is left up to the foster parent to seek it out. There is a desperate need to educate our foster homes to understand the problems of their foster children and just not symptoms. Then not to contribute to their problems, and last when possible to encourage growth and nurturing to occur for re-unification back into the birth home. Many times we see children move back and forth through the system because of the lack of understanding of the dynamics involved.

What this has become affectionately known as is the foster care drift; the drifting of children in and out of ten to fifteen placements. Is it any wonder that children become more emotionally impaired.

Many times children go through the adoption process and still continue to bounce in and out of placements. Approximately, forty percent of our placements in our home in the last five years have been adopted children that were either struggling in the adopted home. Going back to Ricky, I would note that in all the twenty-seven placements that Ricky has experienced, he has never been treated for the sexually acting out, or his social pathic tendencies that have been identified. Please look at his time line for placements, it is a cycle, round and round, just bouncing from foster home to foster home and institution to institution and back and forth never returning to his birth home. Ricky was never really serviced. If left in his birth home, we doubt if he would be worse than what he is today. I can tell you what he is. He is like many like of our other children we have had in our home without social conscience because they have not bonded. If we don't get to them while they are still young we will continue to not only have the Steven Judys' and David Woods' who I am more familiar with because the man he murdered was within five miles of my home and his sister resided in my home for several years.

You read about them in your papers back home. You may not know who your new neighbor is next door. They will look like you and I but they will not have a sense of conscientiousness that you and I have, the

values in society. We will have to deal with it. We are currently dealing with it now in our correctional facilities but we can not build the jails as fast as will be needed if we don't take the time to realize and help work for a solution.

I also might suggest that we not just looking at funding. I would strongly advocate that we take a look at our departments, agencies, and programs that now exist and their cooperation and coordination with one another.

Birth homes are people that need lifted up. Do you know Ricky's birth home is in tack and has not had any charges filed on them and if serviced in his birth home Ricky may not have been the boy that will be let out of the system tomorrow morning.

Families with children having emotional handicaps under the best circumstances need services. When families are placed under less than ideal circumstances with these children we see families breaking up furthering the emotional problems of the child as well as the family. We have witnessed first hand the care and concern for children with physical handicaps and also the hurt and scorn from the lack of services by schools and society with the emotionally handicapped child. Foster Parents are there to respite and help. Foster parent education should be mandatory in every state.

I urge Congress to take a look at the caseloads that caseworkers are handling. I have spoken directly with caseworkers from Cleveland that had caseload of 110 . While Indiana regulates their caseloads to 55 which is only an average.

That is not servicing of children. Children's Bureau is recommending caseloads of 20 to 30, I believe. We have watered the soup down so low that there is very little nourishment left. I have great empathy for those caseworkers that are overloaded and the difficulties that lead to high turnover rates because we give them Mission Impossible. But I am not giving up hope because I am seeing people beginning to cooperate. There was a time when there was no communication.

We are beginning to recognize the need for more specialized foster homes instead of more restrictive settings. Specialized foster homes receive extensive training. We personally went thru three years of training in a pilot program presented in Northeastern Indiana under Wayne Hapner.

I have just recently became aware of a new program called C.A.S.S.P. through working with Parents As Allies. This program has given me new hope that something can be done, that the system is'nt so large that we can't still keep our agencies intact, revitalize them and redirect them toward working with one another. It is necessary to get beyond turf issues and concentrate on solving problems and providing adequate services to children and families.

Having fostered children for the last fourteen years, I have become a team member and team leader. I've called team meetings that included myself, caseworker, probation officer, therapist, guardian ad litem, and school representative, and can say it is possible to get beyond turf issues. As a result some of our worst senario foster children have had successful reunifications and or have experienced positive behavior changes. I was at a Parents As Allies conference last month where birth families from nine states gathered with professionals to share ideas on defining and breaking down the barriers they saw for their emotionally handicapped children. I have included those with my report. Indiana is the crossroads of America. We are a cross section of America. When we lift a child we help that child but when we lift families we still lift that child as well.

Your committee is able to lift families across America, it is my hope that being here today I can encourage you to continue to do so and also to stress the importance of specialised foster homes, the de-institutionalization of children, and the importance of the team concept across the board.

Goals of the Families as Allies

Tennessee

1. Lack of organized advocacy:
    - A. Knowledge of the system and how it really works
    - B. Use of media
    - C. Lack of data
    - D. Lack of coalitions and other groups

2. Service delivery problems:
    - A. Lack of a complete system of care
    - B. Lack of training of professionals
    - C. Structural problems within state government
    - D. Other funding priorities
    - E. Lack of continuity in the treatment of childrens' issues (programs changing from one administration to another)
    - F. Need for more rural programs
    - G. coordination problems
    - H. No commissioner serving directly the issues of children and their families
    - I. Poor quality control and a failure of professionals to take responsibility for failure (a general lack of progress on 'turf' issues)
    - J. Problems with the school system

3. Problems of attitude and perception:
    - A. Blaming/fear
    - B. Lack of adequate knowledge concerning emotional problems
    - C. No recognition of children's needs (and a general disinterest in their problems)
    - D. Communication problems
    - E. Lack of proper training (professionals) regarding the treatment of children and their families.

4. Family/Parent support:
    - A. Need for organized groups
    - B. Lack of respect for families and the need for communication
    - C. Need for respite care
    - D. Lack of knowledge of the system
    - E. Need for improved communication and coordination (a 'team approach' between professionals and families)

5. Need for innovations in funding and resource allocation:
    - A. "More that just state money"
    - B. Need to look closer at local charities (etc.), utilizing every available way to allocate resources (approaching both the private and public sectors, and at all levels)

Illinois

1. Lack of knowledge, communication, and coordination between parents, professionals, agencies, programs, and inter-agency networking).
    - A. Myths (re: parents)
    - B. Parents'/Professionals' lack of knowledge and resources
    - C. Lack of community services due to "Confidentiality Law"
    - D. Level of trust between professionals and parents
    - E. Conflict between professionals (their attitudes toward parents and the needed treatment)
    - F. Lack of state coalition
    - G. Professional detachment
    - H. Professionals' concern (re: lack of parent involvement)
    - I. Service providers "passing the buck" (mandating services only by the 'letter of the law' and a general lack of inter-agency cooperation communication)

2. Lack of appropriate educational programs, services, and legal remedies for children and their parents.
    - A. Inadequate intermediate services
    - B. Lack of comprehension of the degree to which a problem must be (before it is even addressed or acted upon)
    - C. Parent skills to evaluate resources (need professional guidance and treatment)
    - D. Restricted or inconsistent allocation of resources at all levels of government (i.e.--schools, county services, etc.)
    - E. School administration's acceptance of role as the academic supporter of the child
    - F. Lack of parent support-groups
    - G. Inadequate legal intervention
    - H. Professional refusal to place children into special programs
    - I. Lack of appropriate intervention at an early age
    - J. Lack of public awareness and publicity
    - K. Lack of appropriate services (especially to minority families)

3. Lack of needed funds and/or an inappropriate allocation of existing funds.
    - A. General lack of financial resources
    - B. Professional awareness and education as to the finer points of insurance policies and other family-oriented fiscal matters

Michigan

1. Inappropriate attitudes towards emotionally-impaired children and their families
2. Government agencies neglecting the role of parents as allies...
3. Coordination of services...

Ohio

1. Funding issues...
2. Early intervention/prevention (the lack of respite care,an immediate access to services,severe lack of legislative support)...
3. Networking of service providers...

Minnesota

1. "Shame/Blame syndrome"-- patronization of families by service professionals...
2. Lack of system flexibility...
3. Lack of education by professionals;also, the existence of professional insecurity in referring and assistance...

Wisconsin

1. Prioritizing of funds and fiscal incentives...
2. Perception of parents as uncooperative and uninformed...
3. Lack of a clear,central state philosophy regarding exactly what services should be and how they should be provided...

Kentucky

1. Parent-professional coalitions (advocacy and support and understanding)...

2. More funding for services...

3. More community-based services to prevent, in the end, institutionalization...

West Virginia

1. Better communication/mechanisms for parental input...
2. Summer programs (not just within the educational system)...
3. Inter-agency accounting (or responsibility) for the problems...
4. Lack of trained service providers...
5. Resource hot-line approach providing information to parents needed...
6. More resources on a county by county basis; and, the delivery of these services in a systematic fashion...
7. Teachers (and other professionals) need training in developmental psychology, theory, etc. (and, more inservice training)...
8. Community awareness and responsibility in concert with greater advocacy within the legal and legislative structures...
9. Cooperation: **a need for Partnership in Planning services** for Children **(Financial innovations for bringing children back home)...**

Indiana

1. Unstable/inadequate resources for S.E.D.
2. Lack of advocacy efforts...
3. Lack of coordination and cooperation among government agencies...
4. Unwillingness of service providers to tolerate advocacy and the institutional refusal to be accountable...
5. Lack of parent support-groups...
6. Difficulty in assessing care...
7. Lack of parental, public, and professional awareness of the needs and rights of S.E.O.

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Parent- five children ages 8-16 (one adopted)

Foster Home - fourteen years, Specialized Foster Homefive years

Parented- living in a major metropolitan area- Indianapoli
living in a suburb of medium sized city- Fort Wayne
living in a small town- Garret
living on a small rural farm in Dekalg County

Activities-

Parents in Action Advisory Committee for IPS
Marion County Foster Care Task Force
Marion County Advisory Committee on AIDS
Indiana Foster Care Association, Board of Directors-1st Vice Pres
Familiesas Allies
Indiana Chapter of the Association for Persons with Severe Handicapps
Civilian Volunteer Police Officer for the Indianapolis Police Dept.
National Foster Parent Association
Rairden Resource Center for Foster Care-Director

Types of children cared for-

unwed mothers
suicide
emotionally handicapped
physically handicapped
learning disabled
mentally handicapped
minorities-Asian, Spanish, Black

RICKY

Age	Cost	Placement #		Placement	Counseling
0-4	0	1		Birth Home	none
	*	2	two months	Guardian Home #1	none
5-6	$1,712	3	one year	Foster Home #1	none
	480	4	three months	Foster Home #2	none
7	0	5	three months	Adoption Home #1	none
	*	6	three months	Guardian Home #2	none
	480	7	three months	Return to Foster #1	none
	*	8	three months	Guardian Home #3	none
8	0	9	six months	Adoption Home #2	none
	*	10	?	Guardian Home #4	none
	1,712	11	one year	Foster Home #1	none
9	574	12	four months	Adoptive Home #3	begun during last month
	*	13	three months	Guardian Home #5	none
10-12	3424	14	two years	Foster Home #3 Foster placemnt #5 Turns into Adoption #4	began again
13	36,000	15	six months	Institute #1	26hr. by nonprofessional 4hr. by profesional
	0	16	nine months	Adoptive Home #4	cont.
14-15	53,000	17	two years	Institution #2	20hr total without for 7 months
RECORDS REVEAL AT THIS POINT AN ERROR ON BIRTH CERTIFICATE OF ONE YEAR					
14	8,460	18	seven months	Residential Home#1	3/one hrs.
14½-16½	68,620	19	two years	Institution #3	208 hrs. group 52 private
	3,840	20	two months	Residential Home #2	none

Ricky-2

Age	Cost	Placements#	Placement	Counseling
	*	21 one month	Guardian Home #6	none
	*	22 four days	Juvenile Center Correctional Facility	given 3 test costing 1400 to parents
	*	23 ?	Guardian Home #7	none
	*	24 ?	Youth Center #1	none
	*	25 ?	Juvenile Center	none
	*	26 NOW	YMCA	none

* unable to find cost

THIS CHILD HAS BEEN DIAGNOSED TO BE A POTENTIAL THREAT TO OTHERS AND IS TO BE RELEASED WITH OUT TREATMENT FOR HIS SEXUAL MISBEHAVIOR AND IS DIAGNOSED UNTREATABLE. HE WILL BE RELEASED AS A WARD OF THE COURT TOMORROW

July 15, 1987

Indiana

HOUSE BILL 1405

(Summary)

(House Bill 1405 was enacted by the 1987 General Assembly)

HISTORY

House Bill 1405 evolved out of the work of the S.B. 430 Task Force. This Task Force was put in place by legislation passed in the 1986 General Assembly. The Task Force was appointed through the Interdepartmental Board. It's task was to determine the availability of services for children with a diagnosis of emotional disturbance and to identify the service gaps that need to be addressed. The Task Force was mandated to report directly to the Legislative Service Agency with findings on how services could be better coordinated among state and local agencies. The Task Force met bi-weekly through the summer and fall of 1986 and recommendations were presented to the Legislative Services Agency.

House Bill 1405 was written by the Legislative Services Agency to tie state and local agencies together. The goals of House Bill 1405 are to 1) provide coordinated services to children and youth, 2) reduce the use of restrictive care and 3) increase the availability of community based programs. The primary sponsors were Representative Ray Richardson (R) Greenfield, Representative Dennis Avery (D) Evansville, Representative Stan Jones (D) West Lafayette, Representative Brian Bosma (R) Indianapolis, Senator Roger Jessup (R) Summitville, Senator Katie Wolf (D) Monticello, Senator Robert Hellman (D) Terre Haute, and Senator Thomas Wyss (R) Fort Wayne.

PROVISIONS

Sections One and Five of the Bill are designed to ensure more appropriate use of state psychiatric hospitals for children. The Task Force identified problems of responsible county agencies refusing to assume wardship of children who have been hospitalized in state institutions when the children had reached maximum benefit from the hospitalization and were ready for discharge. These two sections assure that the Department of Mental Health will not charge the county welfare departments for state hospitalization of wards, and the county welfare departments will assume wardship of the children upon discharge from state hospitals.

Chairman **Miller**. Thank you very much.

Dr. Saxe.

STATEMENT OF LEONARD SAXE, PRINCIPAL AUTHOR, OFFICE OF TECHNOLOGY ASSESSMENT REPORT ON CHILDREN'S MENTAL HEALTH, AND ASSOCIATE PROFESSOR AND DIRECTOR, CENTER FOR APPLIED SCIENCE, BOSTON UNIVERSITY, BOSTON, MA

Dr. **Saxe**. Thank you, Chairman Miller. Thank you for holding these very important hearings. I have submitted a statement for the record, and I will try to summarize it very briefly.

The OTA report documents what has long been known. The majority of children with mental health problems fail to receive appropriate treatment. Many of the perhaps 8 or 9 million children in need of mental health treatment receive no care; others, perhaps 50 percent, receive inappropriate treatment. The shame of the present system is that we know how to do better. It is not simply a question of scarce resources.

There are several reasons for our current predicament, but one is central, how we pay for mental health care. Rather than children's needs being paramount, treatment is driven by the health care financing system. This system forces hospitalization of children and fails to support community-based services. If we are to develop a more responsive system, the system will have to focus on children as individuals. Instead of avoiding responsibility, we will have to emphasize prevention and treatment in the least restrictive setting.

Children's mental health problems result from an interaction between a child's own condition and the child's environment. A wide array of psychopathology can affect children from infant's problems, such as failure to thrive, to school-age problems, such as hyperactivity, to adolescent problems, such as depression and drug abuse. The child's environment can exacerbate these problems, can help in their resolution, or can precipitate them.

Treatment needs to be as complex as children's problems, yet it is not, at least as the system is available to a typical child. There are a number of treatment choices, but particularly important is the treatment setting. Whether the child is treated as an outpatient, whether in a private office or group home or in a residential facility such as a hospital, the treatment setting affects outcome, and the treatment setting very much affects the cost.

Unfortunately, selecting a treatment setting is typically based not on the needs of the child but on the insurance available to the child or the availability of public programs. As a result, a disproportionate amount of treatment resources are directed at the extremes, individual outpatient treatment or inpatient hospital treatment.

Some changes to the health financing system may only compound the problem. For example, implementation of prospective payment, based on DRG's [Diagnosis Related Groups], fails to take account of the child's overall situation. The result may be restriction of treatment to hospitals or denial of treatment.

There are, however, some encouraging developments. For example, the State of North Carolina is collaborating with DOD at Fort Bragg to build a network of coordinated child-mental-health services. CHAMPUS, the military dependent insurance program, currently spends over $2.5 million per year at Fort Bragg to treat 125 children on an inpatient basis and another 55 children outpatient. Under the demonstration that is being developed, it is projected that 800 children, 4 times as many, can be served for the same amount of money.

Undoubtedly, part of the problem is the inadequacy of resources. Even relative to other health and mental health populations, children are short-changed. The benefits of helping children should be obvious. The troubled children we neglect today are going to be the troubled and costly (to society) adults of tomorrow. We can do better.

What is probably most important is to establish the principle that children have a right to mental health treatment. Establishing that right, perhaps using Public Law 94–142 as a model, would be an extremely important step. There are also a host of specific policy changes that should be considered, and I will run through a quick list.

First, spend the set-aside provision of the ADM block grant to ensure funding for children's services; second, institutionalize NIMH's efforts to aid states in planning children's mental health services; third, expand prevention efforts through grants and set-asides; fourth, ensure that funds are available for research on children's mental health problems; fifth, review Federal health programs to ensure that coverage for children's mental health disorders provides appropriate treatment; do likewise and provide incentives for private insurers; sixth, increase to at least 1981 levels direct Federal support for children's mental health programs; seventh, develop a demonstration program of alternative treatment systems for participants in government health programs; and, finally, eighth, coordinate children's mental health services and programs across Federal agencies.

No single policy change is likely to resolve the problems of our current mental health system for children. The perceived intractability of the problems, however, should not cause us to shrink from our responsibility. There is an urgent need to close the gap between what we know about aiding children and what we are doing.

Thank you, Mr. Chairman.

[Prepared statement of Professor Leonard Saxe follows:]

PREPARED STATEMENT OF LEONARD SAXE, PRINCIPAL AUTHOR, OFFICE OF TECHNOLOGY ASSESSMENT REPORT ON CHILDREN'S MENTAL HEALTH, AND ASSOCIATE PROFESSOR AND DIRECTOR, CENTER FOR APPLIED SCIENCE, BOSTON UNIVERSITY, BOSTON, MA

Chairman Miller and Members of the Committee:

I am pleased to appear today to discuss the problems of care for children with mental health problems. I am Professor Leonard Saxe, a psychologist on the faculty of Boston University and Director of the University's Center for Applied Social Science. I am the principal author of a recent Congressional Office of Technology Assessment (OTA) background paper, "Children's Mental Health: Problems and Services," prepared at the request of the Senate Appropriations Committee. This report is the latest in a series of a reports I developed for OTA on the costs and effectiveness of mental health treatment.

Provision of Appropriate Care

Our OTA report documents what has long been known -- that the majority of children with mental health problems fail to receive appropriate treatment. Many of the six to eight million children in our Nation who are in need of mental health interventions receive no care; other children, perhaps 50% of those in need of treatment, receive care that is inappropriate for their situation. Mental health treatment for children is often provided piecemeal, is disconnected from the child's everyday situation, or is disruptive to the child's on-going family and school relationships. The shame of the present situation is that we know how to deliver appropriate treatment services, but fail to do so. It is not simply a question of scarce resources; in fact, although more resources are needed, we do not spend our precious resources for children well.

The reasons for the present inefficient and ineffective system are many, but one is increasingly central: Our methods for paying for mental health care. Rather than children's needs being paramount in deciding whether and what type of treatment will be proffered, treatment decisions are increasingly driven by the health care reimbursement system. This system is forcing hospitalization of children, even when there are more effective and less expensive alternatives. The system does not provide the continuity of care and provision of out-patient services that should be the central feature of a mental health system. The reimbursement system is distorting conceptions of mental health in an attempt to control health costs. It is neither successful in controlling costs or in providing adequate services.

If we are to develop a mental health treatment system for children that is responsive to their needs, we are going to have to redesign it thoroughly. The focus will have to be on children, as individuals, who live within a family and a community. Our goals will have to change from avoidance of responsibility for providing services until a problem becomes "serious", to one that emphasizes prevention of mental health problems. If problems are manifest, the child should be treated in the least restrictive setting possible and with techniques appropriate to the child's situation.

One of the underlying reasons that we have allowed the reimbursement system to govern care for children with mental health problems is that our treatment system incorporates a fundamental misconception about children's problems -- principally, such difficulties arise from both the child's physical and social environment. Based on my work for OTA, I would like to offer a somewhat different view of the nature of children's problems and the services available to treat such problems. This is the context within which decisions about restructuring the funding of children's mental health services can be made.

Nature of Problems

Children's mental health problems result from an interaction between the individual child's vulnerability to mental health problems and the hazards of a child's environment. Children are highly dependent on their environment; thus, the nature and course of disorders that they have depend both on the child and the stresses or support from their family, school, and neighborhood.

A wide array of psychopathology affects children. For example, infants can suffer from problems such as failure to thrive, while young school-age children may experience school phobia, chronic problems with attention and hyperactivity, difficulties with peer relations and control of aggression. In adolescence, childrens' disorders look more like those of adults (although their treatment needs differ) and include depression, suicide and abuse of drugs, alcohol and other substances. Often, multiple problems appear in an individual child.

The child's environment plays a crucial role in mental health problems and can either exacerbate particular problems or help in their resolution. The environment may even be the precipitating cause for a mental disorder. Poverty, minority status, parental psychopathology, maltreatment, and the effects of divorce, are but a few of the environmental factors which can lead to or aggravate mental health problems in children.

The complex child-environment relationship has a number of implications. It suggests the need for multiple forms of treatment and interventions that address both the child and the child's context. It argues against an emphasis on diagnosis-based systems which establish treatment planning on the symptomatology of the child. It argues for a multi-layered coordinated system of care with an emphasis on prevention of mental health problems.

Treatment

Treatment should be as diverse and complex as children's mental health problems, yet it is not, at least as the system is available to a typical child. Mental health treatment runs the gamut from school-based interventions designed by mental health specialists, but implemented by teachers, to hospital treatment supervised by psychiatrists and other mental health professionals. Probably the most common mental health treatment is psychotherapy, provided on an out-patient basis by psychiatrists, psychologists, or social workers. Such treatment takes on a number of forms, including group therapy and family therapy, and is sometimes combined with other treatments, such as the use of drugs.

Probably more important for policy purposes than the type of treatment is the setting in which it takes place. Individual treatment can take place virtually anywhere, from a mental health practitioner's private office to a hospital ward. Because dealing with a child's environment is a crucial part of treatment, the choice of setting is essential. Whether the child is provided assistance on an out-patient basis or as a hospital inpatient is central, both in terms of outcomes for the child and for the cost of treatment.

Often overlooked in discussions of children's mental health policy is that the treatment system is far more variegated than outpatient vs. inpatient treatment. In fact, there are a vast number of treatment setting models for children, including day hospital treatment, group homes, therapeutic respite care, and various ways of delivering outpatient treatment -- through schools, health centers, juvenile justice centers, and mental health settings. Ideally, the choice of setting should be based on an assessment of his/her family, school and medical situation.

Reimbursement

Unfortunately, selecting a treatment setting is typically based not on the needs of the child, but on the insurance available to the child or the availability of public programs. Currently, disproportionate treatment resources (both public and private) are directed at the extremes -- individual outpatient treatment at one end of the continuum and inpatient hospital treatment at the other end. There are, to be sure, important differences across states, differences between rural and urban areas, and most importantly, socioeconomic differences, but the basic distortion in where resources are placed affects virtually all children.

Consider, for example, a child whose behavior becomes increasingly aggressive and bizarre at school, partly as a result of abuse at home from his or her overwhelmed young, working single mother. The child, having experienced ongoing difficulties from birth, is learning disabled as well. The child may not be able to remain at home and requires mental health services in addition to child protection services. Ideal immediate treatment might include brief placement of the child with a professional parent and intensive crisis intervention involving mother, child and teachers. Longer-term intervention might include intensive day treatment services providing a therapeutic environment to the child along with a parents' support group for the mother.

Yet, this range of services is often not available to the child and mother -- they do not exist or there are not funds (e.g., private insurance, Medicare) to pay for them. Because the only service that is reimbursable may be hospitalization, there may be no other option available. This is unfortunate, because it is more intensive treatment than the child needs and is inefficient in such a case. Once a child is hospitalized, such functions as parent support and work with teachers become difficult both because of the isolation of the hospital from the community and because of the difficulty of paying for such services in a system based on reimbursement of direct treatment methods.

Changes to the health care reimbursement system, to prevent overuse of hospitalization, are only compounding the problem. Thus, for example, implementation of the Prospective payment system based on DRGs (Diagnosis-Related Groups) fails to take account of the child's overall situation. The payment attendant to the diagnosis -- based on an unreliable estimate of length of stay in the hospital and, probably, more benign cases -- would not support sufficient therapeutic work with the mother and the school. The child eventually may be "dumped out" of the hospital. This often occurs without adequate follow-up care, perhaps because there were not adequate funds to allow for planning for subsequent treatment in the community. The abuse, learning disabilities, and child's emotional reactions would continue undertreated, setting the stage for another crisis leading to another hospitalization. Many professionals recognize this sort of scenario, and try to address the inevitable problems of these children within the constraints of the treatment system. But a system geared toward providing narrowly-focused treatment when problems have become severe is probably unfixable.

There are, however, several encouraging developments providing alternative systems of children's mental health treatment. Thus, for example, the State of North Carolina is collaborating with the Department of Defense to build a network of child mental health services at the large Army installation at Ft. Bragg, in Fayetville, NC. The insurance program for military dependents, CHAMPUS, currently spends over $2.5 million per annum on children's mental health treatment at Ft. Bragg. It is estimated that this pays for 125 children to receive inpatient services and another 50 children outpatient services. Dr. Lenore Behar, Director of Child Mental Health Services for the State of North Carolina, projects that 800 children can be served for the same amount of money spent on less than 200 children. This improvement in services will be achieved by insuring that more appropriate treatment in less restrictive settings, is provided. The demonstration project at Ft. Bragg, will be carefully evaluated, both to document its cost-benefit and to assess the quality of care.

Undoubtedly, part of the problem is the inadequacy of resources available to aid children with mental health problems. As a nation, we spend too little on the needs of children and, even relative to the funds spent on other health and mental health populations, children are short-changed. This applies to research, as well as to monies for treatment. Although conducting a formal cost-benefit analysis is admittedly difficult, the benefits of helping children are obvious. The troubled children whom we neglect today are, unfortunately, going to be the troubled -- and costly to society -- adults of tomorrow.

Even without expanding resources available to treat children with mental health problems, we can do far better utilizing available funds. The governing principle has to be making available the most appropriate treatment for a child at as early a stage as possible. This will require developing mechanisms to fund mental health treatment that are not primarily based on labeling a child's psychopathology. We also need to develop means to make a broader range of mental health settings and services available to children and we have to develop the means to coordinate services so that appropriate treatment in the least restrictive setting can be guaranteed.

Conclusion

As a policy matter, what is probably most important is to establish the principle that children, both at risk of mental disorder and those with mental health problems, have a right to treatment. Children do not have the ability to care for themselves -- they would not be children if they could -- and we have an especially important responsibility toward children with mental health problems. Establishing a child's right to mental health treatment, parallel to the provisions of P.L. 94-142 that guarantee a child's right to an education, is perhaps the most important step that Congress could take, even if it did not result in a specific appropriation. Such a provision would, however, encourage states and local agencies to work in concert with government to develop more effective policies.

There are also a host of specific policy changes which should be considered. These include:

-- Expand the set-aside provision of the ADM Block Grant to ensure that children's services have adequate funding.

-- Institutionalize NIMH's efforts to aid states in planning for children's mental health services and requirement that state plans incorporate a continuum of care.

-- Expand prevention efforts through both planning grants and, perhaps, set-asides to require prevention efforts.

-- Insure that funds are available for research on children's mental health problems and that epidemiological and biometric studies be conducted and reported.

-- Review the provisions of federal health programs (e.g., Medicaid), to insure coverage for children's mental health disorders provides appropriate treatment. Incentives should also be developed for private insurers to include adequate and appropriate children's mental health services.

-- Increase, to at least the levels of 1981, the amount of federal support for children's mental health programs.

-- Develop a demonstration program of alternative treatment systems for participants in Medicaid, CHAMPUS and other govenrment health programs.

-- Develop a program to coordinate children's mental health across Federal agencies -- including the ADAMHA components, NIH, other HHS units, the Department of Education, and the Department of Justice.

No single policy change is likely to resolve the problems of our current mental health system for children. The difficulties faced by the troubled children served by this system are extraordinarily complex. The perceived intractability of the problems should not, however, cause us to shrink from responsibility. There is an urgent need to close the gap between what we know about aiding children and what we are doing. The sooner we begin, the more quickly we will reach our goal of better serving those children most in need.

Chairman MILLER. Dr. Knitzer.

STATEMENT OF JANE KNITZER, DIRECTOR, DIVISION OF RESEARCH, DEVELOPMENT AND POLICY, AND SENIOR POLICY SCIENTIST, BANK STREET COLLEGE OF EDUCATION, NEW YORK, NY

Ms. KNITZER. Thank you.

My name is Jane Knitzer and I am very delighted to be here and that you are holding these hearings. I am tempted just to say "amen" to everything that everyone else has said. As you can see from my written testimony, it covers much of the same ground.

Let me just tell you that in 1982 when I was at the Children's Defense Fund, we did a study called "Unclaimed Children". They were called unclaimed because of the failure of public systems. You heard about them this morning. I don't need to say more about that. The OTA report found much the same kinds of patterns of nonservice that we did.

To set a context, though, what I would like to do is talk about some of the changes that have occurred, some of the positive kinds of changes that have occurred since 1982, since we did Unclaimed Children. So let me just very briefly highlight our findings. First, two-thirds of the seriously disturbed children and adolescents do not get services, or get inappropriate ones.

The second major finding was that policy attention to the needs of emotionally disturbed children and adolescents was virtually nonexistent. Shockingly, in 1981 when we did this survey, only 21 States even had one live full-time person working on child and adolescent mental health. You all know how large mental health bureaucracies are; one person.

We also, when we did Unclaimed Children, looked for interagency efforts because, as you know from many of the hearings that you have held on other subjects, troubled children are not just the responsibility of the mental health system but are found in all systems that serve children in child welfare, in juvenile justice, in special education. We therefore tried to find out what States were doing in an interagency way; and we found out, virtually nothing. This was particularly shocking since we know that many of these children are really exchangeable children. Whether they end up in juvenile justice or child welfare or mental health is as much a matter of chance as it is any differences in assistance or in the kids, and that is really very important.

The third major finding was about our only positive one. There were indeed some programs that worked. These tended to be community-based, nonresidential programs, many of them serving children who were on waiting lists for residential services. The programs tended to be, as Dr. Saxe just said, complex, not just therapy, which is not enough for the kids that we are talking about, but therapy with the provision of case management, case advocacy kinds of services to link the children, to package the kind of services that they needed. The problem was that most of these programs were precariously funded and did not have the stability of funding streams that residential services had and continue to have.

The fourth major finding from our study was that advocacy on behalf of these children is woefully lacking and that both the mental health advocates and the general children/generic children's advocates were not paying too much attention to this group of children.

Today, many of these findings, as you have heard, still hold; but some things have changed for the better, and this is largely because of a very small Federal initiative called CASSP, the Child and Adolescent Service System Program. Very small is exactly what I mean. It was initially funded at $1.5 million. Much to everyone's surprise, 44 States applied for that money, which suggested that States were finally beginning to recognize they had some responsibility to meet the needs of troubled children.

CASSP is important because it, first of all, is serving as a catalyst to the states to provide some leadership on children's mental health; secondly, because it requires the states to develop some real interagency efforts; and, third, it calls on states to develop what we have come to think about as systems of care, to provide the range of services that we know we need to have in different communities if children are to be effectively served, and particularly to provide some of the nonresidential services that we are beginning to see really can make a difference: respite care, intensive crisis, in-home family services; what we call in-child welfare family preservation services, and day treatment programs. All of these are absolutely essential, and we have some evidence that they really can make a difference for very troubled children.

The systems of care, of course, should also include some residential components, including specialized foster care, therapeutic foster care, and case management services, which we are becoming increasingly convinced is a very significant way to glue services together for these children who interact with so many different systems and whose family needs are so great for support.

CASSP now is in 28 States. At least 10 of them at the time of Unclaimed Children had absolutely no mental health presence. That, right away, is progress. In addition, I think CASSP has led to a number of important beginning changes, sort of setting the context for some real changes for these children.

First of all, I think it has increased the visibility of children's mental health issues in general. Second, it has set a framework for change in many ways comparable to what permanency planning has done for the child welfare system. There is a vision of where states can go. CASSP has given them some direction.

In some states, there has actually been an increase in targeted funds for children's mental health through the set-aside block grant monies. And some states are also targeting some special monies for children's mental health that they didn't before. There has been, I think, a great increase in parent advocacy largely through efforts of CASSP and some of the states to encourage parents to come together and begin to work with professionals in a different way.

There are some beginning efforts to implement systems of care. Probably North Carolina is the State with the most advanced system of care, and, ironically, that really was the result of a lawsuit, not CASSP. But, nonetheless, it set a very significant model for the rest of the country and said that, in fact, we really could keep children out of residential placement, keep these very troubled, behaviorally disordered children out of residential placement.

I think the other trend that we are beginning to see is some serious interagency efforts that go beyond the usual, "We need more interagency cooperation and collaboration," and I think we can see it in three ways. One is around programs, particularly family preservation intensive crisis programs, where, particularly, child welfare and mental health are coming together. Secondly, we can see it around case management efforts, where a case manager really pulls together the package of services and is there for the child, is one person that the child can connect with and the family can connect with, which is incredibly important in such a fragmented system. So we are beginning to see those kinds of interagency efforts.

Third, we are beginning to see interagency efforts around planning and the development of new services, and CASSP is one model. I know you are going to hear from Randy Feltman later on about a model in Ventura County. Florida has also set up a very interesting model that really tackles the educational issue that has been raised by both the parents this morning. Specifically, Florida, as a result of legislation, provides funds to different regions to bring together education, mental health, and residential services to provide a focus for case planning, case management, generating new services, et cetera. That really, I think, has led to some changes in Florida. Bob Friedman may have some comments on that.

These are all very positive developments, but they only skim the surface, and basically they are really very fragile. CASSP has a very, very small amount of money, and the fiscal disincentives towards providing the system of care that we need that Len Saxe talked about are absolutely critical. We desperately need continued Federal leadership if the momentum that has just been started is to continue. Without Federal leadership, I don't think it will continue.

The first challenge is to ensure that funding and mandates to continue these reform efforts are in place. With, I think, strong leadership from the Federal Government, that can happen, and I would just reinforce what other people have said. Unlike child welfare services or educational services, which really specify a broad mandate, there is now no mandate to provide a range of services to troubled children. In fact, the State legislation around the mental health of children generally concerns the conditions under which a child can be hospitalized only. No statutes call upon the States to provide a range of appropriate services. We need to develop models for such mandates.

Even more immediately, we need to strengthen and expand CASSP. Continued strong Federal support for nonresidential services, for the development of a balanced system of care, and for parental support groups and advocacy is absolutely essential.

The second area where Federal initiatives could make a difference is around the role of a school in meeting the mental health needs of both children and adolescents, and, as you have heard, these children have clearly received less attention than other children identified and served through Public Law 94-142. It is beginning to be clear that there is some activity in the states at this level, and actually I am presently engaged in a study where we are taking a hard look at what the relationship is between the schools and children's mental health, and we are going to need some leadership and help from the Federal Government in moving this aspect forward.

The third challenge, I think, is to focus some programmatic and policy initiatives on behalf of troubled and at-risk younger children. The reality is that most of the current initiatives focus on adolescents. Most of the resources have been targeted to adolescents. We need to use some of the knowledge that Congressman Miller mentioned in terms of infants. We know a lot about working with dysfunctional families, with infants and toddlers, with children who fail to thrive, et cetera. We know a lot about working with preschool children, because we did a lot of that in the 1970's. Most of those programs have been defunded, however.

We need to provide some leadership, I think, so that States will again focus on these younger children, and, informally, I have to say—and maybe others can confirm this—I am hearing that there are more younger, seriously troubled children, and I don't think we have made any response to that. Public Law 99-457 is clearly a step in the right direction, but I think it is going to take more to create a sharper mental health focus.

The fourth way in which the Federal Government can play a significant role is by encouraging and supporting experimentation with funding issues, with fiscal issues. I know you all know about this; I am not going to say anything more. Medicaid, for example, is often not helpful. Money is most easily available for the most restrictive placement, rather than for less restrictive alternatives.

Fifth, I think we need increased incentives for demonstrations of interagency approaches to children's mental health. I think the time is right for these. Child welfare and mental health people are beginning to understand that they have something in common. We need to provide some demonstrations around joint assessments. The problem of emotionally disturbed children being evaluated and evaluated and evaluated is a very serious one. It is also a serious waste of money. We need joint programs, joint monitoring, and especially joint training with people from child welfare, mental health, juvenile justice, et cetera.

Finally, we need Federal help in assessing the impact of some of these new initiatives: Are we really making a difference? I think it is very important that we do some of the kind of hard evaluation of these new services and the new initiatives and see whether, in fact, we are really making inroads in the way services are delivered to troubled children and adolescents.

Thank you very much.

[Prepared statement of Jane Knitzer follows:]

PREPARED STATEMENT OF JANE KNITZER, ED.D., DIRECTOR OF THE DIVISION OF RESEARCH, DEVELOPMENT AND POLICY AND SENIOR POLICY SCIENTIST, BANK STREET COLLEGE, NEW YORK, NY

My name is Jane Knitzer. I am currently the director of the Division of Research, Demonstration and Policy at Bank Street College. Prior to that I was a member of the staff of the Children's Defense Fund where I carried out a national study about children's mental health. That study, Unclaimed Children was released in 1982. What I'd like to do this morning is summarize, very briefly what we found, what progress has been made since then, and what remains to be done on behalf of troubled children and their families.

The CDF Study

First let me highlight four major findings from the CDF study. The first was that children who need services often don't get them. We estimated, conservatively that there are at least three million seriously emotionally disturbed children in this country. Of these, only one million receive services. Moreover, even for those children who do get something, the services are often inadequate. Repeatedly, for example, data that we reviewed showed that between 40 - 60% of the children who were in psychiatric hospitals were there by default, because no less restrictive programs, such as day treatment, or intensive in-home crisis intervention services were available. Parents reported painful, frustrating efforts to get the schools and mental health agencies to provide appropriate services to their children. And, in far too many instances, parents of emotionally disturbed children who need residential care report that they can only get it by giving up custody of their children--in some cases the only way to do this is to charge parents with neglect.

The second major finding was that policy attention to the needs of emotionally disturbed children and adolescents was virtually non-existent. A state by state survey highlighted the incredible reality that in 1981, only 21 state departments of mental health had even one full time staff person assigned to child and adolescent mental health. Virtually all the attention was focused on the needs of chronically mentally ill adults. Only 15 states had any separate service standards for children and adolescents, and almost none could provide information on how much the state spent on child and adolescent mental services other than inpatient care. Interagency efforts on behalf of troubled children were hard to find. This was particularly surprising since both state data and clinical experience point to the reality that troubled children are found in all child serving systems--child welfare, juvenile justice and special education--not just mental health.

The third major finding was that from a programmatic and clinical perspective there were (and are) some program approaches that seem to be responsive to troubled children and their families. These programs not only provide therapy, but also help the children and families with concrete needs--for housing for example, or for changes in IEP's. Informal evidence suggest these programs were (are) successful with children otherwise headed for residential placement. But they were few and far between, and usually fiscally precarious.

The fourth major finding from the CDF study was that unlike many other groups of children with handicapping conditions, emotionally disturbed children were largely unclaimed not only by the states and the federal government, but by advocates as well--in part because of the difficulty of understanding what children's mental health is all about--in part because parents of emotionally disturbed children and adolescents had not organized their own support and advocacy groups.

Current Realities

Today, many of these findings still hold. The recent report of the Office of Technology Assessment, for example, estimated that 80% of the 7.5 million seriously and moderately disturbed children and adolescents do not get services.

But some things have changed for the better. This is largely because of a very small federal initiative entitled the Child and Adolescent Service System Program. CASSP was funded initially at $ 1.5 million in 1983. Now it is funded at $ 5.9 million. (During the 1970's, the federal government through the community mental health centers act provided about $ 20 million for children's mental health services.) CASSP provides money to the state to create or strengthen a policy presence within departments of mental health. But it also requires evidence of meaningful interagency efforts around mentally ill children, and evidence that the state is moving toward developing "systems of care for troubled children." It calls on states and communities, in other words, to support a) a range of non-residential services (such as respite care for parents, intensive in-home crisis interventions, often known in child welfare circles as family preservation services, and day treatment); b) a range of residential treatment services, including therapeutic foster care, and

c) case management services to glue together the many services often involved in a troubled child's life.

The CASSP initiative, although clearly funded at a minimal level, has had an important impact. CASSP grants have been given to 28 states, at least 10 of which were making no efforts on children's mental health in 1982. Most importantly, CASSP, along with the CASSP technical assistance center, two national research and training centers also supported by federal funds and the new visibility to children's mental health have provided some badly needed direction to the states about what to do for troubled children. This, in turn has resulted in a number of changes.

First, there is now widespread recognition that children's mental health issues are part of the larger children's agenda--as witness these hearings. Second, a number of states are putting some new resources into children's mental health, either with state funds, or by using some of the set aside mental health block grant monies. The result is some new services are developing, particularly non-residential ones. Third, parental advocacy is beginning to grow, nurtured in part by CASSP and the research centers. Fourth, in a few places, states (for example, North Carolina) and some communities (for example, Ventura County, California) are trying to implement systems of care. Fifth, new approaches to real, rather than token interagency efforts are emerging within the states. Some of these are focused on specific programs that work for troubled children in all systems, such as family preservation services, others are focused on efforts to improve existing linkages across systems. Florida's legislatively mandated SED Network (Multi-Agency Service Network for Severly Emotionally Disturbed Students) for instance, has resulted in a joint effort between education, mental health and residential services in 15 regions of the state. Sixth, in a scattered way, we are beginning to have data showing that providing community-based services, along with strong case management efforts can really make both a cost difference and a difference in the lives of children. (Florida data on this point are particularly compelling.)

Future Challenges

All these are very exciting and positive developments, but they are also fragile, and barely even skim the surface of the need. The positive developments in children's mental health services, for example, are threatened by the great increase in for-profit psychiatric hospital beds for adolescents--unconnected to any efforts to prevent hospitalization. Moreover, CASSP does not provide money for services, and the reimbursement patterns for mental health services both through insurance companies, and state funds still reward removing children from their homes. These, and other barriers, mean that sustaining the momentum for change will be difficult. Continued and strengthened federal leadership is therefore especially urgent. In particular there are six areas in which we face critical challenges.

The first challenge is to ensure that funding and mandates to continue recent reform efforts are in place both within the states and especially at the federal level. Unlike either child welfare services, or educational services which specify a broad range of obligations, the public mandate to provide services to troubled children largely concerns only the conditions under which children may be hospitalized. No statutes call upon the states to provide a range of appropriate services.

We need to develop models for such mandates. Even more immediately, however, it is crucial to strengthen and expand CASSP. Continued strong federal support for non-residential services, for the development of balanced systems of care, and for parental support groups and advocacy is essential. Without such federal support, it is unlikely that the current momentum will continue.

The second area where federal initiatives could make a difference concerns the role of the schools in meeting the mental health needs of both children and adolescents already identified as troubled under P.L. 94-142 and those at risk of developing behavioral and emotional disorders. Emotionally handicapped children have clearly received less attention than other children identified under the mandate of P.L. 94-142. Often for them, there is nothing more than a token economy classroom. Yet it is clear, from research that I am now involved in, that there are ways to serve them better; ways that link the school with other agencies, and that focus attention on what the children learn as well as how they behave.

The third challenge is to encourage, either through an expanded CASSP program or in other ways, the development of programmatic and policy initiatives on behalf of troubled and at risk younger children. At present, much of the effort around children's mental health has focused on adolescents, and to a lesser extent, elementary school-aged children. State mental health agencies need incentives to focus more energies on the needs of seriously troubled infants and preschoolers, and on young children at risk of developing behavioral and emotional disorders. Given the continued increase in children battered by poverty, abused or neglected by those who care for them, parented by teens who are often ill-equipped for parental roles, and growing up homeless a greater concern with prevention and early intervention seems imperative, especially since we have some strong models. (In this respect, P.L. 99-457 is clearly a step in the right direction, but probably not enough.)

The fourth way in which the federal government can play a significant role is in encouraging and supporting experimentation with alternative forms of reimbursement to fund systems of care. Some states are already undertaking small efforts, but serious inroads can only be made if the federal government is involved.

Fifth, we need increased incentives for and demonstrations of interagency approaches to children's mental health to encourage such efforts as joint assessments, joint programs, joint monitoring, and especially joint training with children, welfare, special education, and juvenile justice providers and agencies at the state level, and multi-agency planning and case management at the local level.

Finally, we need federal help in assessing the impact of some of these new initiatives in children's mental health--are they making a real difference in the lives of real children and families? Here too, federal support and leadership in funding programmatic and longitudinal evaluations can provide crucial cost and impact data as well as a needed perspective on the emerging initiatives on behalf of troubled children, adolescents and their families.

Chairman MILLER. Thank you.

Dr. Friedman.

STATEMENT OF ROBERT FRIEDMAN, DIRECTOR, RESEARCH AND TRAINING CENTER FOR IMPROVED SERVICES FOR SERIOUSLY EMOTIONALLY DISTURBED CHILDREN, FLORIDA MENTAL HEALTH INSTITUTE, UNIVERSITY OF SOUTH FLORIDA, TAMPA, FL

Mr. FRIEDMAN. Mr. Chairman, members of the committee, I'm very happy to be here today to participate in this very important set of hearings that I hope will continue the increased Federal focus on the needs of emotionally disturbed children.

I was asked first to discuss the issue of the prevalence of emotional disturbance in children. Unfortunately, this is not an easy task. The complexity in defining and measuring emotional disturbance in children and the cost of conducting epidemiologic research have held back progress in this area.

However, at our research and training center we recently conducted a review of studies done in several countries during the 1980's. In five of the seven studies reviewed, the overall point prevalence of emotional disturbance ranged between 14 percent and 19 percent. This means that at any point in time 14 to 19 percent of young people in the population surveyed may be experiencing a moderate or severe emotional disturbance. Such disturbance may be transient or long-standing.

This does not indicate that the public sector needs to plan to provide services for such a large percentage of children. In some cases, particularly with less serious problems, there will be improvement without treatment. In other cases, treatment will be provided in the private mental health sector or in the nonspecialty mental health sector.

For purposes of planning with public funds, it is more useful to note specifically the prevalence of serious emotional problems. These are the problems that tend to have a major impact on the day-to-day functioning of the individuals involved or are pervasive in that they affect performance in several settings and are likely to persist or worsen over time without assistance.

Data for determining the prevalence of serious emotional problems, unfortunately, is even less adequate than that for determining overall prevalence, partly because of the absence of adequate longitudinal research. Using pervasiveness of disturbance as an indicator of severity, the proportion of disturbed children in need of services is reduced, and our estimates are between 5 percent and 8 percent.

With regard to persistence of emotional problems, there is general consensus in the field that problems such as aggressiveness, impulsiveness, and noncompliance are more likely to endure than problems of anxieties and fears. About all we can conclude at this time because of the few studies that have addressed this issue is that the percentage of children with problems that are the most seriously handicapping, pervasive, and persistent, is something less than 5 percent.

Several efforts to plan children's mental health services in the public sector have based their plan on the assumption that 1 percent to 2 percent of children may require services at any point in time from the public sector, and such estimates seem reasonable based on the available data on prevalence and on patterns of service utilization.

While this percentage of children for whom the public sector should plan services is considerably lower than the overall prevalence, indications are still that our public systems are falling considerably short of effectively reaching even these children who are most in need.

The emotional difficulties that children experience vary considerably in type as well as in severity. These problems can and do range from serious depression to moderate anxieties and fears and from highly aggressive behavior to noncompliant behavior of a more passive nature. The consequence of these problems may include suicide, serious harm to others, and inability for some youngsters to live within their families. Some of these problems may be a reaction to temporary environmental stresses, such as loss of a loved one, and others, and particularly the most serious problems, are part of a long-term pattern of difficulty in functioning effectively.

Much as the behavior of the youngsters varies, so too do their socioeconomic, ethnic, and racial backgrounds. Families historically, as we have heard today, have been inappropriately blamed for the problems of their children, and the reality is that many disturbed youngsters come from very caring and very competent families.

Our research and training center at the Florida Mental Health Institute, with funding support from the National Institute of Disability and Rehabilitation Research and the National Institute of Mental Health, is currently conducting a four-year longitudinal study of over 800 seriously emotionally disturbed children served in the public sector in six States.

Children in this study were interviewed using a structured psychiatric interview that permits multiple diagnoses. The most common diagnosis was conduct disorder, with over 60 percent of the children receiving this diagnosis. A conduct disorder diagnosis indicates the presence of aggressive behavior, poor impulse control, and difficulties in interpersonal relationships. The long-term outcome for youngsters with this diagnosis is not favorable, and the potential cost to society is enormous.

These youngsters with behavioral disturbances do more than just show aggressive behavior; 53 percent of them also receive the diagnosis of anxiety or depression, and this reflects the fact that with youngsters with the most serious problems, we see those problems reflected both in their overt behavior and in their internal emotional functioning. These youngsters often also suffer intellectual and cognitive problems, social skill deficiencies, and family conflict.

It is not possible to determine at this time whether the prevalence and/or severity of emotional problems of children has really increased over the last few decades. It does appear, however, that the burden to the public sector has grown. Families in the 1980's experience increased strain, as evidenced by high rates of child abuse and neglect, separation and divorce, children living in poverty and single-parent households. These strains have made it more difficult for families to deal with children with serious problems.

Similarly, the problems of the children have added to the strain already present in many families functioning at a marginal level. As a consequence, the public system has clearly acquired an increased responsibility not only for treatment but also for family support, and particularly when that family support is lacking for out-of-home placements.

In recent years, there has been a growing consensus about the types of services needed for emotionally disturbed children and particularly those with multiple and serious problems. Essentially, there has been increased recognition that overall the need is not for one or two particular magical services but, rather, for an overall system of care that provides a range of services, flexibility to tailor services to meet individual needs, that is community based and family focused, is balanced between the more and less restrictive services, and is interagency in focus.

As Dr. Saxe pointed out, while there is considerable knowledge about how to serve these youngsters, unfortunately, there is a large gap in application of this knowledge. Particularly troubling is that the field of children's mental health services continues to be characterized by an over-reliance on out-of-home placements, often in expensive residential settings that not infrequently cost over $100,000 per year, and often in settings far removed from the youngster's home. In one State I visited recently, there were more than 400 youngsters placed out of the state in residential placement settings.

This problem of placement of children at a distance from home was addressed in Florida through a successful Bring Our Children Home Campaign which is now being carried forth nationally by the National Mental Health Association.

Unfortunately, within most States appropriate family-focused and intensive alternatives to residential treatment programs have not been developed despite their cost-effectiveness, and the largest portion, often two-thirds to four-fifths, of mental health funding for children goes towards residential services.

While these services are an important part of a system of care and are absolutely needed for some youngsters, an imbalance in a system of services and an over-reliance on residential placement results in children and families being separated at great human and economic cost, oftentimes when it is not necessary.

It should be pointed out that there is a trend in the public sector toward increased development of the intensive and relatively nonrestrictive services, such as day treatment, intensive home-based and family preservation services, case management, and therapeutic foster care. However, at the same time, there is a concurrent trend towards increased private psychiatric hospital beds for youngsters within the private for-profit sector.

This trend in the private for-profit sector can be positive if effective public-private partnerships can be developed. However, this has been rare. It is a very risky trend because it may result, and has already begun to result, in the overuse of expensive services for which a need is artificially generated by aggressive marketing strategies, by fiscal incentives towards hospitalization, by persistent lobbying of state legislators by large corporations to get policies favorable to hospitals, and then by the dumping of children on the public system by the private system after the insurance benefits have been used.

There are several encouraging developments in recent years on behalf of services for emotionally disturbed children that I would like to emphasize. On the Federal level, as has already been mentioned, a very positive effort has been the Child and Adolescent Service System Program, or CASSP, operated by NIMH. This program has contributed to an increased emphasis on children's mental health services within states, stronger planning, and interagency collaborative efforts.

As a part of this effort, an improved technical assistance capacity was developed partly through the Georgetown University Child Development Center. In 1984, for the first time, two research and training centers were established to focus specifically on seriously emotionally disturbed children. These are funded jointly by NIDRR of the Department of Education and NIMH and are located at the Florida Mental Health Institute, where we are fortunate to sponsor one, and Portland State University. These centers conduct critical research in the field, provide consultation and training, and make a variety of materials available. The joint funding of the centers is one example of the type of interagency effort at a Federal level that is needed.

Within States, interest in services for emotionally disturbed children and particularly in building systems of care is probably at a peak, though our estimate is that probably only about 15 percent of state funding for mental health goes for children.

There has also been increased recognition of the important roles of families as advocates and as allies in planning and implementing services and of the general importance of advocacy on behalf of children. There has probably been less growth in system-focused research activities than in the service area.

Within education, there has been a gradual increase in the number of children identified and served as seriously emotionally disturbed under the Education For All Handicapped Children Act. However, still less than 1 percent of schoolchildren are identified, and efforts to evaluate the impact of school-based services for this group so that we can really know whether we are helping these youngsters are seriously lacking.

In summary, emotional disturbance is a serious problem in terms of its prevalence, in terms of the human impact it has on the children and families affected, and in terms of its cost to society. While the problems of children and families are varied, there is general agreement about the need for balanced, community-based, family-focused systems of care with strong alternatives to residential treatment and with fiscal structures to support these.

While there has been encouraging growth and interest in the field and new and more effective models of service have been developed, many youngsters are still inappropriately and ineffectively served, if served at all.

The following recommendations are offered: At a Federal level, there needs to be continued support of the CASSP effort, the research and training centers, and interagency activities on behalf of emotionally disturbed children. There needs to be an increased emphasis on system-oriented research targeted specifically for this group, and plans should be developed to conduct more longitudinal and epidemiologic research. Unless there are increased efforts within the National Institute of Mental Health and other agencies to focus specifically on children, then the attention continues to be largely on adults within the mental health field.

Efforts to strengthen the impact of the Education For All Handicapped Children Act for this population and to systematically assess its impact should be continued. At all levels of government, there needs to be a continued emphasis on building community-based systems of care with a particular focus on alternatives to residential treatment. Such alternatives are economical, promote family preservation, and are in the best interests of many children who end up being separated from their parents. There needs also to be an increased effort on the entire prevention and early intervention area both for younger children and older children.

All levels of government and both the public and private sector need to reexamine the fiscal structure for services. This is critical given the limited financial resources available and the increasing need to provide cost-effective services. Reimbursement mechanisms and alternative financing strategies should be studied with the goal of providing flexible funding that will meet the child's need for services rather than restrict the range of options available. Medicaid policies need to be closely examined to ensure that they don't contribute to excessive use of hospitals instead of alternatives.

In my State of Florida at the present time, there is an effort by the private psychiatric hospital sector to include inpatient hospitalizations for children under the State's Medicaid plan. In essence, this would really be a subsidy for the private psychiatric hospitals at great cost to the State.

Finally, there needs to be a reexamination of professional training issues in mental health—this was illustrated by the example that Glenda Fine gave of her experiences with the mental health system—and in related fields to ensure that students acquire skill in and an understanding of newer approaches to working as part of multi-agency teams on behalf of multi-problem clients in the public sector.

Thank you.

[Prepared statement of Robert M. Friedman, Ph.D., follows:]

PREPARED STATEMENT OF ROBERT M. FRIEDMAN, PH.D., DIRECTOR, RESEARCH AND TRAINING CENTER FOR IMPROVED SERVICES FOR SERIOUSLY EMOTIONALLY DISTURBED CHILDREN, FLORIDA MENTAL HEALTH INSTITUTE, UNIVERSITY OF SOUTH FLORIDA, TAMPA, FL

Scope of the Problem

The initial step in addressing a social problem is determining its scope. To provide mental health services for children and adolescents, the prevalence of emotional disturbance must first be determined. Unfortunately, this is not an easy task. The complexity in defining and measuring emotional disturbance in children, and the cost of conducting epidemiologic research have hindered progress in this area.

A recent review conducted at our Research and Training Center, however, provides several prevalence estimates (Brandenburg, Friedman, & Silver, 1987). This review discusses findings from general population surveys conducted in several countries during the 1980's. These studies used similar techniques in sampling populations and defining emotional disturbance.

In five of the seven studies reviewed, the overall point prevalence of emotional disturbance ranged between 14% - 19%. This means that at any point in time fourteen to nineteen percent of young people in the populations surveyed may be experiencing a moderate or severe emotional disturbance. Such disturbance may be transient or longstanding.

The overall prevalence estimate offered here of 14% to 19% is somewhat higher than the 11.8% median estimate presented in the late 1970s for the President's Commission on Mental Health (Gould, Wunsch-Hitzig, & Dohrenwend, 1981). This 11.8% estimate was based primarily on studies using teacher ratings conducted prior to 1980. The higher estimate offered here may reflect changes over time, different measurement strategies, changes in diagnostic systems, or different samples.

This does not indicate that the public sector needs to plan to provide services for such a large percentage of children.

In some cases, particularly with less serious problems, there will be improvement without treatment. In other cases treatment will be provided in the private mental health sector, or in the non-specialty mental health sector.

For purposes of planning with public funds, it is more useful to know specifically the prevalence of serious emotional problems. These are problems which tend to have a major impact on the day to day functioning of the individuals involved, are pervasive in that they affect performance in several settings, and are likely to persist or worsen over time without assistance.

Data for determining the prevalence of serious emotional problems is even less adequate than that for determining overall prevalence, partly because of the absence of adequate longitudinal research. If the pervasiveness of disturbance is used as an indicator of severity, the proportion of disturbed children in need of services is reduced. Brandenburg et al. (1987) noted consistency among recent studies in the proportion of children identified as disturbed both at home and at school. Most estimates ranged between 5% and 8%.

With regard to persistence of emotional problems, there is general consensus in the field that problems such as aggressiveness, impulsivity, and non-compliance are more likely to endure than problems of anxieties and fears (Quay & Werry, 1987). About all that can be concluded at this time from the few longitudinal studies addressing these issues is that the percentage of children with problems that are seriously handicapping, pervasive, and persistent is something less than 5%.

Several efforts to plan children's mental health services in the public sector have based their plan on the assumption that 1% to 2% of children may require services at any point in time (Behar, Holland, & MacBeth, 1987; & Friedman, 1987), and such estimates seem reasonable based on the available data on prevalence, and on patterns of service utilization.

While the percentage of children for whom the public sector should plan services is considerably lower than the overall prevalence, indications are still that our public systems are falling considerably short of effectively reaching the children most in need (Friedman, 1984; & Knitzer, 1982).

Types of Problems

Children experience emotional difficulties that vary considerably in type as well as severity. These problems can and do range from serious depression to moderate anxieties and fears, and from highly aggressive behavior to non-compliant behavior of a more passive nature. The consequences of these problems may include suicide, serious harm to others, and an inability for some youngsters to live within their families.

Some of these problems may be a reaction to temporary environmental stressors, such as loss of a loved one, while others (particularly the most serious problems) are part of a long-term pattern of difficulty in functioning effectively. As the recent Office of Technology Assessment Report indicates (1986), "mental health problems are a source of suffering for children, difficulties for their families, and great loss for society."

Much as the actual behavior of youngsters varies, so too do their socio-economic, ethnic, and racial backgrounds. While families have historically been inappropriately blamed for the problems of their children, many disturbed youngsters come from very caring and competent families.

Our Research and Training Center at the Florida Mental Health Institute, with funding support from the National Institute of Disability and Rehabilitation Research (NIDRR) and the National Institute of Mental Health (NIMH), is currently conducting a four-year longitudinal study of over 800 seriously emotionally disturbed children in six states. This study is focusing on children who are receiving at least some publicly-funded services, and therefore the results may not be representative of all youngsters with serious emotional problems. As part of the study, information is being gathered about the youngsters by directly interviewing them, interviewing their parents, getting reports from their teachers, and reviewing case records.

Children in our investigation were interviewed using a structured psychiatric interview that permits multiple diagnoses. Conduct disorder was the most common diagnosis in the sample. Over 60% of the children and youth received this diagnosis. A conduct disorder diagnosis indicates the presence of aggressive behavior, poor impulse control and difficulties in interpersonal relationships. The long term outlook for youngsters with this diagnosis is not favorable. Many of them will continue to engage in socially inappropriate behavior as adults.

These youngsters with behavioral disturbances are more than just "bad kids", however. Fifty-three percent of them also received a diagnosis of anxiety or depression. They may commit bad acts but they also suffer serious emotional disturbance.

The multiplicity of difficulties these youngsters experience extends beyond the fact that over 70% of them received multiple diagnoses. They also suffer intellectual and cognitive problems, social skill deficiencies, and family conflict. As this study proceeds, it should provide important information on the long-term outcome of these problems both for the children and families involved, and for society.

It is not possible to determine at this time whether the prevalence and/or severity of emotional problems of children has increased over the last few decades. It does appear, however, that the burden to the public sector has grown. Families in the 1980s experience increased strain, as evidenced by high rates of child abuse and neglect, separation and divorce, children living in poverty and in single parent households. These strains have made it more difficult for families to deal with children with serious problems. Similarly, the problems of the children have added to the strain already present in many families functioning at a marginal level. As a consequence, the public system has acquired an increased responsibility not only for treatment but also for family support and often for out-of-home placements (particularly when family support is lacking).

Services for Emotionally Disturbed Children

In recent years, there has been a growing consensus about the types of services needed for emotionally disturbed children, and particularly those with multiple and serious problems (Behar, 1985; Friedman, 1986; Knitzer, 1982; OTA, 1986; Stroul & Friedman, 1986). Essentially, there is increased recognition that the overall need is not for one or two particular "magic" services, but rather for an overall system of care that provides a range of services, flexibility to tailor services to meet individual needs, is community-based and family-focused, is balanced between the more and less restrictive services, and is inter-agency in focus. While the knowledge to serve all youngsters effectively is still not present, there is an accumulation of information suggesting that there are effective treatments for many youngsters, and that the application of these treatments is lagging (OTA, 1986; Stroul & Friedman, 1986).

In particular, the field of children's mental health services has been characterized by an over-reliance on out-of-home placements, often in expensive residential settings, and often in settings far removed from a youngster's home. This problem of placement of children at a distance from home is not uncommon and was addressed in Florida through a successful "Bring our Children Home" campaign which is now being carried forth nationally by the National Mental Health Association.

Unfortunately, within most states appropriate family-focused and intensive alternatives to residential treatment programs have not been developed, and the largest portion of mental health funding for children goes toward residential services. Residential services are an important part of a system of care, and are absolutely needed for some youngsters. In particular, some encouraging models of therapeutic foster care have been growing (Update, 1986). However, an imbalance in a system of services and an over-reliance on residential placements does not serve children or families well, and is inordinately expensive for public systems.

It should be pointed out that there is a trend in the public sector towards increased development of intensive and relatively non-restrictive services, such as day treatment, intensive home-based and family preservation services, case management, and therapeutic foster care. However, there is a concurrent trend towards increased psychiatric hospital beds for youngsters within the private, for-profit sector (Miller, 1985; Schwartz, 1985). This trend in the private for-profit sector can be positive if effective public--private partnerships can be developed. It is risky if it results in over-use of expensive services for which a need is artificially generated by aggressive marketing strategies and fiscal incentives towards hospitalization.

Although there is general agreement about the need for balanced, community-based systems of care, there are a number of barriers impeding progress toward the development of such systems. These include a lack of clarity about responsibility for these youngsters, inadequate efforts by agencies to work together, professional attitudes that interfere with the development of newer models of service, fiscal incentives and reimbursement mechanisms that emphasize residential treatment, lack of adequate advocacy for improved services, and absence of knowledge in the general mental health community about newer services. These barriers must be addressed, and are discussed later in recommendations.

Developments in the Field

There are several encouraging developments in recent years on behalf of improved services for emotionally disturbed children. On the Federal level, a very positive effort has been the Child and Adolescent Service System Program (CASSP) operated by NIMH. This program has contributed to an increased emphasis on children's mental health services within states, stronger planning and inter-agency collaborative efforts, and enhanced training. As a part of this effort, a much-needed improved technical assistance capacity was developed through the Georgetown University Child Development Center. The CASSP program along with related service system efforts is part of a newly developing Child and Adolescent Service System Branch at NIMH.

For the first time in 1984, two research and training centers were established to focus on seriously emotionally disturbed children. These are funded jointly by NIDRR and NIMH and are located at the Florida Mental Health Institute and Portland State University. These Centers conduct critical research in the field, provide consultation and training, and make a variety of materials available. For example, to help disseminate information about new developments in the field and to make it easily readable by busy policy makers, the Florida Center publishes the only national newsletter that focuses specifically on new efforts in the field. The joint funding of the Centers is one example of the type of inter-agency effort at a Federal level that is needed.

Within states, interest in services for emotionally disturbed children and particularly in building systems of care is probably at a peak. This is very exciting since states have the major responsibility for planning, funding, and overseeing children's mental health services. There is also increased recognition of the important role of families both as advocates and as allies in planning and implementing services, and of the general importance of advocacy on behalf of children.

There has probably been less growth in system-focused research activities than in the service area. Despite the fact that there is much knowledge that is not yet being used, there are many important questions about the organization and financing of systems of service that remain to be studied. There is a particular need for increased attention to system financing and management structures, and their impact on services, at both a Federal and state level.

Within education, there has been a gradual increase in the number of children identified and served as "seriously emotionally disturbed" under the Education for All Handicapped Children Act (OSERS, 1986). However, still less than 1% of school children are identified, and efforts to evaluate the impact of school-based services for this group are lacking.

Summary and Recommendations

In summary, emotional disturbance is a serious problem in terms of its prevalence, the human impact it has on the children and families affected, and its cost to society. While the problems of children and families are varied, there is general agreement about the need for balanced, community-based systems of care with strong alternatives to residential treatment, and fiscal structures to support these. While there has been encouraging growth in interest in the field, and new and more effective models of service have been developed, many youngsters are still inappropriately and ineffectively served, if served at all. Those services that have been in operation for the longest period of time, such as psychiatric hospitalization and school-based services, tend to be among the least well-evaluated for effectiveness.

The following recommendations are offered:

1) At a Federal level, there needs to be continued support of the CASSP effort, the research and training centers, and inter-agency activities on behalf of emotionally disturbed children. There needs to be an increased emphasis on systems-oriented research targeted specifically for this group, and plans should be developed to conduct more longitudinal and epidemiologic research. Efforts to strengthen the impact of the Education for All Handicapped Children Act for this population, and to systematically assess its impact, should be continued.

2) At all levels of government, there should be a continued emphasis on building community-based systems of care with a particular focus on alternatives to residential treatment. This will require flexibility in the systems, good management structures, strong support of families, and fiscal incentives for non-residential services. It will also require that there be a coordinated, multi-agency approach to planning, funding, and operating programs.

3) All levels of government, and both the public and private sector, need to re-examine the fiscal structure for services. This is critical given the limited financial resources available and the increasing need to provide cost-effective services. Reimbursement mechanisms and alternative financing strategies should be studied with the goal of providing flexible funding that will meet the child's need for services, rather than restrict the range of options available.

4) There needs to be a re-examination of professional training issues in mental health and related fields to insure that students acquire skill in and an understanding of approaches that involve working as part of multi-agency teams on behalf of multi-problem clients in the public sector.

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Chairman **Miller**. Thank you very much.

If I am hearing all of this testimony in a correct fashion, it would seem to me that you are describing a system where, if a child receives treatment, proper treatment, appropriate treatment, that that child is, in fact, the exception, not the average child, certainly not the rule by any stretch of the imagination.

What worries me is, in almost all of your recommendations, in the discussion of saying what we really need is a range of services and what we need is case management, that you are sitting here this year after decades of looking at this problem saying what this ought to be is a child-based, family-based operation, and we ought to look at these families and these children individually, and we ought to figure out what is going to be helpful to that particular person, and then make an application of those services.

But what you have is a child like Ricky, who is running throughout the system, and nobody quite knows where he is at any given time, and really what you are doing is just figuring out how you are going to pay for Ricky. You just shuffle him off between different programs. Today, I'm sure you would be trying to provide "homeless" funding for Ricky because there would be some avenue of funding available.

He reminds me of the old thing of the clerk stamping; he is just getting his portfolio stamped as he moves from age one to 18. If you just look at the dollar amounts that were spent on him, where little or no—in most cases, where no counseling or services were provided other than shelter, this is a very expensive child.

Now when you couple that with the notion, Mrs. Gaunt, that he is going to be released tomorrow or today out into society, and you look at the history of his problems and the history of services that were provided for him, chances are he is going to get very expensive as an adult. Not even addressing the issue of whether he is going to become dangerous or not, he is going to become very, very expensive. If this were a racing form and we were looking to see how he was going to run on the track tomorrow, we would say we have one dangerous horse here.

It is hard, I guess, for me to accept, as one of you started out by saying, that we know what we should be doing, but then immediately revert to the notion that we are not doing it. Again, in addressing all of your testimony, there is a strong suggestion, to be polite, that what we have is children in search of reimbursement rather than children in search of placement, and that you have the combination of state legislators and hospital corporations driving reimbursement toward empty hospital beds. Now in my area, those beds are being taken up by AIDS patients, so I am not sure that is going to work much longer.

But, in fact, what we have in the San Francisco Bay area is a lot of overbuilt hospitals who decided that this wing could be farmed out to some private care unit and we could lock up children, and then in six months we could deliver them back to their families for a happy reunion. The evidence starts to suggest that that is not really true; what we do is, we deliver them to the public service because now, as you pointed out, Dr. Friedman, they have creamed the insurance reimbursement system, and now they are just disposing of the child and making room for another.

I just wonder if you might address this, because obviously a couple of you have referred to the fact that CHAMPUS is now rethinking this reimbursement system, that there is a way to offer lower intensity, more appropriate care to a greater number of families and children in need, and yet each of you has touched upon the notion that reimbursement is driving the decisions as opposed to the needs of the families with the children.

I just wonder if we could have a bit of expansion, because we are somewhat responsible for reimbursement systems also, to whatever extent we match or provide.

Maybe we will start with you, Dr. Saxe.

Mr. SAXE. Yes, Chairman Miller.

Chairman MILLER. It took you about three sentences to get into this issue.

Mr. SAXE. Right. It is a fact. The shame of it is that we have known for a long time. You go back to the White House Conference on Children in the early part of the century, and then the White House Conference during the 1930's on Children and Families, the Joint Commission at the end of the 1960's, the President's Commission in 1978. Everybody has said the same thing: We have got to move in this direction.

Now as illogical as the system may seem, there is a kind of perverse logic to it which explains how Congress has allowed it to happen and how private insurers have. The idea was, well, we don't want everybody to get services, because if we open it up too wide, then every kid on the block is going to have services. The public purse is then going to be empty, we won't have money for defense and other important things, so we have got to restrict it to those most in need. This means the severest cases, and since we can't demonstrate very easily the benefits unless we do a very complicated cost/benefit analysis, we can demonstrate the benefits at least to budget people of helping kids and preventing serious disorders. We had this system focused on the most severely disordered.

The assumption of the system was fallacious, that if you wait until the end it will be cheaper to take care of. If you get it early, if you provide a community-based system, you can serve a lot more kids at a lot lower level and provide in the end what we now know is much better care. As other people have pointed out in different ways, there is an important Federal responsibility here to try to turn around this system that has gone haywire.

Chairman MILLER. Anybody else?

Mr. FRIEDMAN. I think there has been a real carryover from the general medical field that has influenced this dramatically. There has been the notion that hospitals are a benign place for treatment, at worst, if not actually the desired place for people with serious problems.

In the children's mental health field, as Dr. Saxe said, for a long while there was concern, and there continues to be some concern, that it is hard to identify who the kids are and that obviously those people with the most serious problems need the most expensive treatment, that being hospital treatment.

In reality, in the children's mental health field, there is not any indication that hospitals are any more capable of serving kids with more serious problems than some of the intensive nonresidential services and some specialized residential services in nonhospital settings.

There is evidence that when a child is removed from his or her family, that is extremely disruptive, and what is going to make the difference is probably not so much what happens while the child is in the hospital, but whether anybody is working with the family while the child is in the hospital, and what services are going to be provided afterwards? Those seem to be the critical things.

But I really think there has been a carryover to look at the hospital as the place to treat those with the most serious problems. That doesn't seem to be supported by the data. It is supported, clearly, by the fiscal incentives that over the last few years have become even more pronounced as insurance benefits have become greater and as the profitability of psychiatric hospitalization for children has increased.

Ms. Gaunt. I would like to reiterate a point that, Mr. Miller, you made. I am not a professional person in the sense that I don't have the expertise that the other people on this panel have, but you brought to mind a child who was in my home just this past year, Shannon, an inner-city black girl who was released out of a psychiatric hospital after two months of services. She was in my home, and in that two months I felt we were doing pretty good, and all I got was a half-hour of counseling out of it.

I am a specialized foster home, and——

Chairman Miller. Keep that up, and you will be a professional.

Ms. Gaunt. I can't share how frustrated I feel. I felt that I let that child go, but, you know, I knew there was no way by myself I could continue the care of that child. If I could have just had some support, if I could have gotten the counseling quicker, and faster, and more intensive, I could have kept that child, and I really feel with all my heart that child would be in placement and be much farther than she is today. It was like the hospital was to be a panacea; it was the end, and that was it.

So this institution we paid over $400 for, on top of the psychiatrist, went into my home as a specialized foster home with a minimum rate of $25 a day, and we couldn't even provide any services.

Ms. Knitzer. I just want to underscore the implications of what you are saying, and that is, one of the real problems that we haven't specifically articulated is that very often mental health funds mean that you have to see the child, you can't talk to the foster parent; you can't get reimbursed for doing work with a foster parent.

Chairman Miller. How can that be in this day and age?

Ms. Knitzer. I don't know. It has been that way for a long time, and you have heard this a lot.

Chairman Miller. I know I have heard this a lot, and, in fact, heard it in other descriptions of the same child. You know, we meet this in the juvenile justice system or the foster care system; it is all the same child. I mean we sort of have the same population wandering around from service to service.

But how do we cling to a reimbursement system that suggests that you can't—I mean the child is a component of this family, and I think Stuart or somebody else in the other panel is going to start telling us that we are starting to receive children because of disintegration of families because of drugs or alcohol. Do we really think we are going to short-circuit that process by looking at the child and then putting the child back in that nest a month later? 60 days later? 90 days later? What is the evidence that that approach works?

Ms. KNITZER. We don't have any.

Chairman MILLER. There is none, is there?

Ms. KNITZER. No.

Chairman MILLER. I mean if you look at the number of children that have wandered through the system under that approach, they have just waited out the system.

Ms. KNITZER. There really is none. That is what is so terribly frustrating.

Chairman MILLER. But you are saying there are formal rules of reimbursement that preclude you from talking to the foster parent or talking to even the birth parents, the natural parents, of this child.

Ms. KNITZER. Well, you can talk to them, but you can't get reimbursed for it.

Chairman MILLER. That precludes a lot of discussion, let me tell you, in this day and age.

Ms. KNITZER. Exactly. It is a very short conversation, that is right, and this is not a new problem.

Chairman MILLER. But you are saying that that is really the current model for delivery of these services. Is that right?

Ms. KNITZER. It is in most places, yes.

Chairman MILLER. Except where the Department of Defense figured it out in North Carolina.

Ms. KNITZER. Yes.

Mr. SAXE. Well, the Department of Defense, I don't want to give them too much credit.

Chairman MILLER. I'm willing to give them a lot at this point.

Mr. SAXE. The State of North Carolina, Dr. Lenore Behar, who is the head of their Child Program, was instrumental in that, and, as a result of language that I think Senate Appropriations wrote into the DOD appropriations this year, this program was essentially mandated by Congress. Although CHAMPUS is experimenting with various things, it is not something that they naturally developed. The state came to them and said, "Please let us help you take care of this large group of kids who are being sent off because there aren't services in the Fayetteville area." They are being sent all over the country to residential treatment centers.

Mr. FRIEDMAN. And there are other examples. The state of knowledge has advanced beyond that, and I think there are demonstrations of effective services. However, they are too few and too far between, and I think what troubles me is that we are becoming more aware (and the folks in the public sector who are extremely concerned about the cost of services and reaching the largest number are looking for these kinds of solutions) but, at the same time as the public sector is moving in one direction to let's work with the family, let's provide that support—and that was an excellent illustration the home, to keep a child in a home with his or her parents or foster parents—at the same time there is this conflicting trend and pressure from the private for-profit sector that is not without its influence on what goes on in the public sector. That trend is really towards where we had been for years, either outpatient treatment, and, if that doesn't work, into a hospital. Even where the hospital is built by the private for-profit hospital by itself, it has its cost to the public sector and contributes to draining some of the resources for the other kinds of services that we have been talking about.

Ms. KNITZER. Let me just say one other thing about this, because it really puzzles me, too. I think part of the problem is that traditional mental health services, which really do mean sitting and talking to a child or a parent, et cetera, simply do not work for this large population of kids, and the mental health professions themselves, both psychologists and psychiatrists, have really not rushed to do all the other kinds of things that are necessary to provide appropriate treatment to these kids. So it in some ways is a comfortable stance, I think, for many of the professionals clinically as well as in terms of reimbursement; and that is part of what makes it so hard to challenge.

Chairman MILLER. Congressman Coats.

Mr. COATS. One thing that I heard most of you stress is the lack of agency cooperation. I hear this at home as I meet with the agencies there and talk with the people. They all agree there is a woeful lack of coordination and cooperation between agencies. Yet every attempt that is made to try to bring that together, to coordinate that, results in failure, probably because no one really wants to give up any turf. They all want to retain their funding, they all want to retain their jobs, and they all want to build their statistics to show that they really are meeting the needs. They all probably have somewhat of a parochial feeling that, "We really do a little bit better job than the rest, and I'm not sure we want to turn our clients over to that."

How do we break through that? How do we achieve that coordination and cooperation between agencies that almost everyone here, I think, agrees needs to be done?

Ms. KNITZER. I think there are some signs that some of the States are really trying. It is baby steps, but, for example, in Pennsylvania recently all the county agencies agreed to have one annual meeting; the probation officers, the directors of special ed, the child welfare people, all had one meeting focused on how they could begin to work together. Obviously, an annual meeting is just a first step, but, nonetheless, this was unprecedented that they all came together. The model in Florida, the SEDNET model that I mentioned earlier, is also a step in the right direction.

It is hard to know what the magic ingredient is. Some of it is getting people talking to each other, and some of it is having some incentives. CASSP, for example, is really serving as an incentive.

Mr. COATS. Well, I find they are now all talking to each other. There is a lot of talk going on about how all of us pull together. I don't see a lot of action.

Ms. KNITZER. Well, there are a few things we can cling to, but, as usual, they are scattered.

Mr. COATS. Sometimes I feel like we almost ought to mandate a czar over all the social services for a particular area and let that person direct how the whole thing is going to fall in place.

Mr. FRIEDMAN. That approach is being used in some places.

Mr. COATS. Explain that. How does that work?

Mr. FRIEDMAN. The approach of having more of an umbrella human services agency and having it perhaps on the state level or on a community level.

Mr. COATS. It probably almost has to be directed from the state level, doesn't it, since so much of the funds and the administration of the funds come from the States?

Mr. FRIEDMAN. Yes, but it is not sufficient if it is just at the state level. It almost has to be replicated at a community level, and there are those communities that do it in spite of the absence of leadership from the State.

I think that the agencies listen most not to us professionals but they listen most to legislators, parents, and advocates, and folks have not paid much attention to the needs of these kids who fall between the cracks and are not clearly defined as being the responsibility of one system or another.

What I see happening is that there is more effort. The CASSP program has contributed to that, some new funding policies have contributed to that, but perhaps more than anything else, people are getting more adamant, they are getting more angry, they are getting more irate at the fact that agencies are not only in some cases not cooperating but in some cases almost running parallel competitive systems with each other.

I would hope that state legislators and others would be much more demanding that there be joint budget requests from agencies, and that is beginning to happen, that there be joint planning of services for groups like this, and I think some of that is beginning to happen.

I really think that, left to their own, each agency has good people who are overwhelmed by their responsibilities, who are overwhelmed and don't have the resources and are looking for direction. I think, left to their own, it would be a very slow process, and, really, the impetus is going to have to come from the higher up policy-making levels of government with a strong push from the advocates.

Ms. GAUNT. I would like to point out that the State of Indiana has passed House bill 1405, which mandates that the groups do get together and do as a team take a look at our children before they go any further into the system past foster care. I have found that very encouraging.

Mr. COATS. Was that piece of legislation based on something that has been tried in another state or was that originated in Indiana?

Ms. GAUNT. I will be honest. I heard almost nothing about this House bill until after the fact, and I felt so greatly encouraged about it, I wondered why I hadn't heard anything from my perspective. But I also understand that not everybody was happy with that. As a parent, I found it the most encouraging thing that could happen.

Mr. COATS. Who was unhappy with it?

Ms. **Gaunt**. Well, whenever we have got groups trying to work together, again, they are not necessarily going to be happy that they are going to have to sit down all together, so it is probably some of those same parties that are struggling over turf issues and the same parties that were still struggling to get together. That would be my guestimate, and that is all it could be. But I find it very encouraging, and I would hope to see it implemented in the next year and carried out.

Mr. **Coats**. My feeling is that there will be some communities that, through the extraordinary leadership of a person or extraordinary cooperation or communication, will set up their own interagency cooperative efforts, but probably for the most part we are dealing with a situation where the law almost has to mandate this kind of action. That gives them the reason to go ahead and do it, and probably it has to be tied to funding, I would think.

Mr. **Friedman**. Absolutely.

Ms. **Fine**. I just wanted to say one thing on that. I think it is wonderful to talk about what the agencies should be doing and what the states should be budgeting, but what I don't see happening is services translated down to the local level, parents spoken to at the local level; everything is at the state level, and we see nothing happening at our local level.

That is something that I think we all have to be very careful about, that these services do get translated, and the children do get what they are supposed to get, and that parents aren't told—this is something else that you were talking about—parents are told, "If your child goes in the hospital, he will be there about 30 days, and everything should be fine." At the end of the 30 days, they leave the hospital, there is no instant cure, and the parents are out on that ocean of not knowing where to go again. That goes back to the hospital being an instant cure; it is not.

If they had services for children in their own homes, people who could come in and stay in the house, and watch what goes on in the home, and help the parents there, that would be much better than sending them to hospitals for 30 days just to use up their insurance money for that year.

Mr. **Saxe**. Yes. I think the financial link of agencies is particularly important. What we may have to do is go toward capitation systems where there is an actual financial link between all of the service systems, there is a pot of money to take care of the child, and it is somebody's responsibility to make sure that that is best spent. That is why in some closed systems, like the military, where the military is responsible for whatever happens to the child or the family, it is easier to do demonstrations, it is easier to tie these things together.

Mr. **Coats**. Let me just pursue one other line quickly here. Most of our discussion has revolved around treatment and intervention, and particularly early intervention, but what are your thoughts regarding prevention? Maybe you don't have thoughts or don't have answers, but what kinds of things should we be exploring and talking about in terms of preventing it in the first place?

Mr. **Friedman**. I think that is a critical area. One of the most difficult dilemmas that state administrators have is trying to balance out what they consider—and I agree with them—is a serious responsibility for those who have the most significant problems, with the recognition that unless they do something at the front end they are not going to make any long-term progress.

I think we need to recognize first of all that there is a variety of types of problems that we are talking about. Some of them, a low percentage of them, but some of them have more of a biological origin, and the approaches to prevention need to involve more basic research in that regard.

But many of them involve a significant component of family strength, of support to the family, of identification of youngsters who are beginning to show learning and emotional and behavioral problems at an early age, and that we can identify families at risk, youngsters in those families, and begin to work with them at an early stage.

We have spent some time talking about foster care, and we should recognize that any child, whatever age, who is abused or neglected and has to be removed from his or her home because of that is at risk for emotional problems as well and that all of these cannot be separated.

So I would suggest that there is much that can be done and should be done in this area, that we don't have the knowledge to address all of the forms of emotional disturbance in children, but that in many of those, particularly where there is a strong family and environmental component, where families mean well and want to help and need the support and assistance, or where children have already experienced trauma and need the services at an early stage, we should be directing much more of our efforts towards them.

Ms. GAUNT. I want to thank you for asking that question. I thought nobody would.

At 7:30 or 11 o'clock at night, when the case workers have all gone home and I've got that kid all to myself, I can tell you just what I need, and it is much the same as what a birth parent needs, because I am just respiting birth parents a lot of times. I have intensive training, and I am able to handle that child and understand them and not contribute to their problems.

Birth families many times are not bad people. My father was a foster child, and I have a great deal of empathy for birth families that are under stress. I am not out to adopt other people's children, and neither would I have done it with the child that I had except that that child just could not go through one more placement, and I did not have the heart to pass him on.

But respite care, quality respite care, for these children, because these are kids—with the breakdown of their home and the destruction of marriages, they cannot get away from these kids. When you are talking about kids like Jason and Ricky that are pounding on your nerves 24 hours a day, respite, as dumb as it sounds, is something that is extremely valuable. Somebody supporting, if somebody could come into that home right then, if that home is not educated—I'm not talking about that they haven't had training.

I have parented a lot of children, but the emotionally handicapped children take a great deal of understanding and education to be able to work with and handle them.

My commitment level is extremely high after having been the child of a foster child, but, at the same time, it was that education that has held me together and has provided stability for my adopted son. It is the one thread that the therapist says may pull him through, so I hang in there. He is fortunate to be in one of the only specialized foster homes in Indiana, and it is because I came from a pilot project in northeastern Indiana, and I am very thankful.

Mr. SAXE. Prevention is probably one of the most important new areas of research and, I think, one of the areas where we are learning lots of new things about how to help children before problems become serious.

As Bob said, we are now getting a much better handle on what are the at-risk conditions, and that makes it possible for us to intervene before it is necessary to remove a child from a home or the child gets so out of control that the teacher doesn't want to have to deal with him.

Mr. COATS. What are those at-risk conditions?

Mr. SAXE. They are everything from conditions of family instability, a parent being alcoholic, separation of the parents, psychopathology in the parents. There are other things that just appear in the child. For example, a child that may be overly shy in school or abnormally shy in the first or second grade may not be able to develop the peer relations that are necessary to learn school material, to learn how to develop social skills.

Identifying kids who have problems early on, even if we wouldn't call them psychopathological, we wouldn't want to send them to a therapist, but indentifying them and intervening may be very useful.

There was an interesting experiment a couple of years ago in England where they identified with parents and teachers kids who were just exhibiting abnormal behavior. They tried a variety of interventions. Those kids six months, a year, a year and a half down the road were doing significantly better than kids who hadn't been treated at all—very cost-effective kinds of interventions.

NIMH has a research centers program in prevention. What NIMH now needs to do is to take the findings of this research program and implement them, and the states need to implement them, and there is a crucial link that needs to be made there.

Ms. KNITZER. Can I just quickly say that we don't do anything with prevention. There are levels of not doing anything. I was really shocked in Unclaimed Children.

Chairman MILLER. Could you say that a nicer way?

Ms. KNITZER. I thought at least that we would pay some attention to children of mentally ill parents in the mental health system, and we found almost no programs for those children or for children who were addicted or substance abusers. There is a very clear high-risk population. That isn't even talking about the general poverty issues: housing, homelessness. We are clearly in need of some massive interventions that go beyond, I think, a narrow mental health definition of prevention, but even that we don't do very much.

Mr. COATS. Thank you.

Thank you, Mr. Chairman.

Chairman MILLER. Congressman Holloway.

Mr. HOLLOWAY. I really don't have any questions because I didn't hear the testimony of the witnesses, but it is such a tremendous burden we have out there. How do we handle it? Exactly what direction are we taking? From the testimony of you all or from your answers, I am not sure that even—I am hopeful that you would have the answers from experience in this on a daily basis, but it seems to be a pretty tremendous problem that we do have to try to do something with.

Undoubtedly, we do have money there. It is just a matter of trying to put it together and get it to work in the right direction or try to pool our resources and what is out there to where it is effective.

I know that this is probably the one aspect of our society where the problem is so complicated that it is going to be quite a mountain to climb to try to put the right agencies in the right places. I wish, if there were any further discussion or answers that you all have to this problem, you could touch on them at this point, because I think the whole solution to the problem is, if we can just ever figure out how to get these agencies all working in the same direction in a way that they can be effective.

Ms. KNITZER. There is a model in CASSP though, and I think it is a very important one, and it is a direction, particularly if we can link it with some of the other kinds of relevant reform efforts—for example, permanency planning. Federal leadership in linking those two efforts, I think, would be really very significant.

There is not a lot of Federal money in children's mental health; there is shockingly little Federal money in children's mental health, targeted monies. I think CASSP is now only $5.9 million.

Chairman MILLER. Excuse me. Your argument is that CASSP does this—right? It appears that it is bringing these agencies together and bringing about some coordination?

Ms. KNITZER. Yes.

Chairman MILLER. Is that what you are telling us?

Ms. KNITZER. I think it is probably the best thing we have going in terms of a framework for moving forward. As everybody has said here, obviously, getting the services in place, however, really means dealing with some of the fiscal issues, and those are the tough ones, the reimbursement systems.

Mr. HOLLOWAY. I have no further questions.

Chairman MILLER. Congressman Durbin.

Mr. DURBIN. One of the things that we have been told repeatedly is that where the Federal Government has cut back in funding for this type of program or has held it steady, that the states have moved in to fill the gap. We have been told that in education, for example, where, over the past six years, under this administration, we have almost held the line at the same dollar level of spending at the Federal Aid to Education Program. Yet the suggestion has been made by Secretary Bennett and others that that really doesn't tell the whole story. The majority of the money on education is being raised and spent by state and local units of government.

I see here that since the Community Mental Health Centers Act was repealed in 1981 and folded into the block grant we have seen an actual decline in Federal spending for that block grant since 1981. Can you tell me whether the suggestion that the local and State governments have moved in to fill this gap and to provide the needed resources is accurate in this instance?

Mr. FRIEDMAN. The needed resources are not there. I have not seen evidence that state governments have moved in in a significant way to fill the void. There are some data that show that state mental health expenditures for mental health services have increased at a relatively steady rate, at least in the early 1980's. So there has been some growth. However, we are in a situation where we are playing such a catch-up game where the funding was inadequate to begin with.

Part of the problem is clearly the way the funding is structured and the way the funding is used. But I don't want to diminish the fact that part of the problem is that there is just an absence of adequate resources also, and I really, particularly over the last couple of years, have not seen indications of large amounts of new funds that are coming for the kind of services we are talking about.

Ms. KNITZER. I think it is important to distinguish between general mental health budgets and targeted monies for children, and it is very clear. For example, the only targeted monies now for children through Federal dollars are CASSP monies, and some States have used the set-aside from the block grant, but basically most of the block grant money goes for the adult chronically mental ill.

There is some evidence, and I haven't seen any systematic survey, of community mental health centers cutting back on children's services, which tend to be more costly because you need more specialized people; somebody who deals with pre-school children may not be so good working with an adolescent, whereas that is not necessarily true in dealing with adults.

So there is some evidence that the easiest thing to do is to reduce children's outpatient mental health services, for example, which have never been very extensive to begin with. There are many community mental health centers in this country that have no children's specialists at all.

Mr. SAXE. If I could just add a couple of things. One is that the ADM block grant, the first appropriation for it was approximately half of what the amount had been previously under what was then the Mental Health Systems Act, the Community Mental Health Centers Program. That has created a tremendous problem.

Now there is a lot of money being spent on children, and some of the burden has been shifted to the private sector, but our analyses for OTA indicate that it is going in the least efficient places. There has been a substantial shift to private hospitals and hospitalization in nonpublic facilities. That is tremendously costly and serves only a couple of kids. That is the story today.

Also, it should be pointed out that the National Institute of Mental Health has lost funding to do some of the basic biometric and epidemiological studies which are necessary even to tell us how much of an effect the funding shifts have had since 1980. We are just not able to collect and report the data any more.

Mr. DURBIN. If I can ask one other question, and forgive me for trying to draw parallels with concerns we have about education, but we have found that many of the health issues and education issues at the Federal level run in parallel. What about the level of quality and competence of counselors in the system? We know now that we are losing many good teachers because, frankly, we don't pay them enough; they are not attracted to the profession.

In my congressional district, a high school counselor once told me that the only young men and women who come before her interested in teaching can't spell the word "college," and that is a sad commentary when you think that we are going to be turning over our children and grandchildren into that system. Now that may be too harsh, but I think statistics suggest that we are losing some of the best and the brightest from the teaching profession.

I would like to apply that to your circumstance here. I have read the testimony where some of you have had experiences with people who clearly were not the best at diagnostic ability in terms of problems that the children were encountering. Is this endemic to the system? Was this an exception? Are we really preparing people or encouraging them to get involved in this?

Ms. KNITZER. The answer is no, we are not really preparing people and encouraging them to get involved.

There are difficulties at all levels. There really are not very many mental health people trained specifically in child and adolescent services, and when they are trained, very often their training is traditional and trains them to do either outpatient or inpatient therapy rather than the more complex kinds of treatment that we are talking about. So that is a tremendous issue.

It is also a tremendous issue with respect to personnel in the schools. The most serious teacher shortage for working with handicapped kids is in seriously emotionally disturbed children. There is the greatest amount of burnout among those teachers. They get almost no support whatsoever, and I think there is some real question as to how we are using mental health resources in the schools. Because of Public Law 94-142, most mental health professionals do little else except test, which may not be the best way, the most cost-effective way of really using their time, because it isn't clear that those evaluations ever feed back into a plan for working with the child either clinically or educationally.

So the issue of resources and the pool whom we select is a very critical one, and actually I suspect that both the APA's have data on the shortage issue around person power.

Ms. GAUNT. Since I deal on a regular basis with these kids and take them regularly for their counseling and all, it was really surprising when I moved to the eleventh largest city in the country that there were no black therapists at the facility that is contracted to provide services for my county. Now that was really difficult, to take my emotionally handicapped inner-city black to someone that he really could not begin to relate to. It set us up for failure.

In response to the schools, the way schools handle it is, they ignore you. You tell them that you would like to have the child tested, you put it in writing several times, you make some phone calls, the child gets suspended, the child gets arrested on a minor altercation at school, and after that you pick up and move to another part of town where you try for a better school that is going to try to respond to your child.

Let me tell you where I moved. I moved into a house directly behind the emergency shelter center in my city, and I picked that house for one reason, because I figured if those schools worked with those kids, 100 kids every day, they must have learned something.

But, you know, if the school does not recognize a child is S5, they do not have to pay for that education of that child, so he becomes the problem of Welfare, or Probation, and they ignore their responsibility.

So I have also found from personal experience that I think sometimes our private services are better than some of the ones we are mandated to use. Medicaid, I can use any therapist, but if it is a child from my local county, right now, I can only use the center which does not have any black therapists and doesn't necessarily meet all my children's needs. So my children have to be molded into what is available right there.

That is unfortunate. I think foster parents would really like to see—because I think I could get my kids back home even faster, and I have probably one of the highest success rates, I feel, for a specialized home, to get my kids back home.

Mr. FRIEDMAN. Let me perhaps be a little upbeat for a change on that question, and it perhaps relates back to Mr. Holloway's earlier question.

First, if we look at where we are in this field in relation to what the need is for services for children and families, we have a tremendously long way to go, and there is just tremendous pain and anguish as a consequence of the deficiencies in the system.

However, if we look at where we are now in 1987, we can be pleased that there is more interest in the field, and there have been more new programs and services developed. Although it is not the rule around the country, there are some models of very effective community systems of service, some agencies are beginning to work together, so that, in a sense, we have made substantial progress. The CASSP program that has been referred to has been one of the impetuses for it. The whole movement of state mental health leaders for children has contributed to that. So there have been some positive things.

In the area of training of professionals though, we have moved fairly rapidly in developing new program models, and one of the things that I think has happened is it has made the training of professionals become somewhat obsolete fairly rapidly.

What we have learned a seriously disturbed child requires now in the 1980's is something different than the kind of talking therapy that we used to think of 10, and 15, and 20 years ago. So many of the folks who are out there and many of the people who are training our new generation of education and mental health professionals really don't have the skills and the knowledge and the experience to provide the training, and maybe even more seriously, they have the kind of attitudes that are inclined towards more of the traditional approaches that sometimes prevent that.

It is unfortunate that, even within our public universities, it seems to me there is a major gap between what the public sector needs in terms of the type of training for social workers, counselors, teachers, psychologists, psychiatrists, and the type of training that tends to be provided in the universities. The type of training is much more geared toward people who will be working for more third-party payments or outpatient and hospital kinds of services.

Mr. DURBIN. If I could ask a followup question on that, could you identify any universities, colleges, or sources of training that you think are innovative now and responsive to modern needs, modern therapy, as opposed to the more traditional methods you discussed?

Mr. FRIEDMAN. Well, in fact, the National Institute of Mental Health has funded some programs to begin to develop curricula that are geared that way. I am hard put in the children's area. In the adult area, I could mention several that are looking at much more psycho-social models with a heavier case management focus.

Frankly, one of the fields that has played such a leading role over the years has been social work, and that has been a field that has been much more aggressive in reaching out to families, and they are beginning to move away from that.

So I am hard put—and others may be able to—to mention specific universities as exemplary.

Ms. FINE. I just wanted to mention that while speaking with several parents last week, they asked me to bring you a message.

These parents and many other parents throughout the country want their children with serious emotional problems to remain in their own homes. The parents I spoke with felt that the money spent on foster care and residential placement should be used to provide intensive in-home services which would dramatically reduce the risk of out-of-home placements. Family coping skills, respite care, education and therapeutic services are but a few of the services that would reduce the risk of out-of-home placements.

Chairman MILLER. Congressman Hastert.

Mr. HASTERT. Thank you, Mr. Chairman. I'm sorry for being late, but I am interested in what the topic is here and going through some of the testimony.

Let me just ask some opinions to get the feel of where you are coming from here. On your statement about universities, isn't it probably true—at least my experience in the state legislature, carrying the appropriation bills for all these agencies for a number of years, for instance, social workers wanted to organize and become certified, and they wanted to get certified through the university system. It seems that instead of being the spontaneous and innovative type of programs that you need to meet the state of the art, once you start ingraining that system and institutionalizing, quote/unquote, whatever a social worker is you become more static and are less flexible. What is your reaction to that?

Mr. FRIEDMAN. Yes, but there needs to be a balance. There clearly need to be some protections and safeguards and some certification procedures, but I think the caution that you are raising is an important one. We need to be cautious of that and not set up a procedure that is conservative and works against innovation and progressive change.

Mr. HASTERT. The people that I saw coming to me were the oldtimers who were protecting their turf, and that is exactly why they wanted the certification, from my point of view, and would really stifle new ideas, new programs, and the flexibility that you need to adjust.

One more frustration while we are talking here, in Illinois—and I see that there is a synopsis of Illinois problems, and I probably agree with most of those—we had rather a broad range of agencies that dealt with children's problems.

One of our biggest problems was meeting Federal mandates. You know, the block grant money came through, but when the Federal mandates came through, sometimes what appeared to be a very minor portion of that program because the mandates drained off a very major part of the resources, both from general revenue funds and from block grant funds. How do you react to that? Do you see the more mandates that come down from on high, the more difficult it is to meet specific needs and solve problems?

Mr. SAXE. In the case of children, I think the set-aside which essentially mandated certain kinds of services amounted to only a small portion of the block grant funds, less than 10 percent, and that was an appropriate share of the funds that should be spent. The problem was, the pot was too small, or the pot is too small.

Then go back to your question about training. One of the most important ways that innovation has been maintained over a long period of time—20 years, I think—is the program of training grants in the National Institute of Mental Health. Giving universities funds to innovate, to try new things, has been one of the ways to develop new models. Over the last five years, virtually all money for people who were going to do clinical work has dried up. There are no longer NIMH training funds, certainly not on the order that there were 10 and 15 years ago, and that, from a university's perspective, is inhibiting our ability to train people.

Mr. HASTERT. That is interesting, because the experience I had was that the most innovative and new programs came out of those people who were the providers, who were on the street, who met the problems day in and day out, and not academia, who is sitting up there and trying to pass paper down through level after level after level of bureaucracy. So I disagree with you.

One of the things that we found—and I was the sponsor of a bill that put forward training grants—a check-off system in Illinois for child abuse prevention happened to be that specific program, just to circumvent those academia, the universities that went on theory and weren't down in the field of practice. We found that the best programs and probably the most effective programs were the programs that came off the street, those people who had to deal—the foster parents, the people who had to deal with the problems day in and day out; they had the answers; it wasn't academia.

Chairman MILLER. Thank you.

If the news isn't bad enough, it appears that for this next fiscal year of the CASSP program, I think we have 19 States that have applied for funding—it appears that we are only going to be able to fund 4 of those states that Congressman Coats and Congressman Holloway and others have talked about in terms of bringing some interagency agreement and cooperation. It appears that it is going to take longer than some people have anticipated, and that appears to be the bright spot in this testimony this morning, so that concerns me.

My other concern is that in the set-aside that we did have, apparently, we have included more under-served populations than just children now. I think Senator Hatch expanded it to the homeless and to others. So we have the same pot of money that has now been diluted by people who are clearly in need of these services, but, nevertheless, we have not expanded that pot.

I assume that when we talk about the providing of services, and when we then get to the poor and the minority communities, we are just talking about this problem in a much more exasperated condition than our discussions this morning. Is that fair to say? I think that is the subject of another hearing, but your experience, I assume, would lead you to believe that that is the case, that the services are much less likely to be appropriate and be provided in that fashion in that community.

Thank you very much for your time, and your testimony, and your help. As you know, this is an ongoing effort of the Select Committee to look at mental health in young children, and we appreciate your help very much.

The next panel that the committee will hear from will be made up of Stuart McCullough, who is the director of the Contra Costa County Department of Mental Health from Contra Costa County, California; Marilyn Mennis, who is the vice president of service administration, Philadelphia Child Guidance Clinic, Philadelphia, Pennsylvania; Bertrand L'Homme, who is the executive director of City Lights, Washington, D.C.; Thomas Davis, who is the mental health program manager, Alexandria Mental Health Center/Children's Services, Alexandria, Louisiana; Randall Feltman, who is the program manager, Children's Services Demonstration Project, Ventura County, California; and Judith Shanley, who is the assistant commissioner, Erie County Department of Mental Health, in Buffalo, New York.

Welcome to the committee. Again, to the extent to which you can summarize your testimony will be appreciated—as you can see, the testimony is raising a number of questions with members of the panel—so that we can leave time for those questions. Your entire statement and supporting documents will be made part of the formal record of this hearing.

As we usually do, we will leave the record of this hearing open for a period of 2 weeks so that people have an opportunity to respond or provide additional documentation or information that they think will be helpful to the committee.

Stuart, we will start with you. Thank you for coming on relatively short notice; but it is either here or the Board of Supervisors; you can take your choice. We appreciate it, and we will start with you.

STATEMENT OF STUART McCULLOUGH, DIRECTOR, CONTRA COSTA COUNTY DEPARTMENT OF MENTAL HEALTH, CONTRA COSTA COUNTY, CA

Mr. McCullough. Thank you, Congressman Miller.

In California, Governor Ronald Reagan in the early 1970's cleaned out the State hospitals and transferred the responsibility for caring for the mentally ill to the local level. In California, the local level means the counties, and we were wholly unprepared to take on that responsibility. There was, in fact, no political orientation to our boards of supervisors; they were wholly unprepared to take on a clinical and administrative responsibility, and there was no clinical and administrative infrastructure set up to accept these folks.

In addition, the governor usurped a tremendous percentage of those dollars into his general fund, which is partially the reason that we had such a large surplus, and, as a result, the mental health system in California has been on a poverty basis ever since.

We were primarily focusing on the adults through this early process, and in the last 10 years a very strong lobby has developed across the State to demand that we provide services to children. We now have what is called Eglin language in California stating that the community mental health system, if it isn't spending at least 25 percent of its funds towards the treatment of children, must spend 50 percent of all new dollars for that end.

I would like the committee to know today that in California, and I'm certain in all the other States, we are seeing an increasingly more disturbed and difficult child. Children are more violent, they are more suicidal, there are incredibly high rates of increases of violence; we are seeing very poor family communication. We believe it is a seriously under-understood problem of the polydrug phenomenon in families and in children. Half the kids we are seeing are, in fact, polydrug abusers.

We talked a moment ago about staff training.

Chairman MILLER. Children, or the family, or both?

Mr. McCULLOUGH. Both.

We talked about staff training. Staff awareness of drug abuse, and how to treat it in the family, is woefully inadequate.

In California, we are not talking just about poor folks, we are talking about all income stratas in terms of family disintegration. In the social services, probation, special education departments, all of them recognize that at the root they are dealing with mental health problems and refer to us consistently to help them out.

We are under the gun in California because of increasing State mandates such as SB-14, which made our social services departments become just what you heard earlier, which are basically protection mills, where we are pulling children out of homes really without much idea what we are going to do with them once we get them out of those homes.

We have seen a 400 percent increase in the rate of child abuse reporting in California. In California today, there are 9,000 children placed out of home in intensive residential treatment facilities. The cost is $220 million a year, and that rate is growing at 20 percent per year. That is only for the most intensive residential programming. It doesn't count the less intensive foster care system.

In our probation department, juvenile probation officers are carrying case loads of between 65 and 80, typically in the range of 80, children a day. There is no way on earth they can adequately serve that number of kids. Our outpatient clinics have a waiting list typically of 50 children. We are triaging. We are only seeing those children that are imminently hostile—that is, violently hostile or imminently suicidal.

There are studies that are showing that one in four children today will be born into a home where one or both parents will be significantly abusing substances. One in three female children and one in seven boys, according to a study recently completed at Mills College, will undergo some sort of abuse.

The mental health system in California, as you have heard earlier, is flat-out overwhelmed. All the other departments are asking us for help. We are trying to cooperate as best we can and to provide services, with the exception of the Social Services Department, to these kids, but we are being constantly criticized for not doing enough. The pain is that we know we are not doing enough.

There are some things that are occurring, and you are going to hear down the line here about the Ventura Project, a model program in California to try and help departments work together. In Contra Costa County, we have the Services Board where the mental health director, the social services director, the chief probation officer, and the county administrator meet monthly.

We have been, and I personally have been, criticized as part of that group for not doing enough by our children's advocates. They have organized themselves into subcommittees of that board and are now basically kicking us around, some saying, "You're not doing enough. For instance, you don't have a system set up where your line staff talk to one another," and I am embarrassed to say, in fact, we didn't. But it is our local lobby that has been demanding that we start to do that kind of planning together, where it isn't just department heads meeting but also, in fact, our line staff is starting to talk to one another.

They have also asked us and, in fact, taken the lead for us in organizing a placement committee where we have organized to see if we can increase the number of residential placements—that is, group homes—in our county, and since that group was formed six months ago we have seen an increase of 80 beds. That is almost a doubling of the beds in our county, and it is again because, at the local level, things are getting organized. And I think that is really what I would like to drive as my theme today: that we really have got to get organized at the local level if we are going to, in fact, really affect this problem.

Anything you do at the Federal level, I would ask that it include incentives. For instance, if you want departments to work together, rather than mandating it, I would suggest that you try and create systems under which it pays for us to work together. We are all very competitive people, and if you put us in a position where we have to go for dollars and demonstrate that we can work together, I think you will see a significant improvement in that area.

In Contra Costa County, we are clear that if we double the budget, if we double our budget in mental health, probation, social services and special education, we couldn't keep up with the need. It is huge. What can we do as government, what can any of us do?

What we have begun to organize under the leadership of our county administrator, Phil Batchelor, is a number of symposiums on the family. We have formed a family alliance foundation in which we are trying very hard to find, locate, and publicize programs that often are not expensive, that are working to improve family communication, working to make parenting a high priority in our society, working to make being a parent, being a family member, as important as being successful, being powerful.

We are having a lot of success with these symposiums. The latest one brought the leaders from the education system, private enterprise, county schools, private organizations, and social clubs like the Rotary Foundation, all together for a day to talk about ways we could strengthen the family, because it is at that level we are really going to have to make some impact.

We can pull these 9,000 kids out of abusive homes; we can pull 18,000 kids out of these homes, and spend a billion dollars. Those kids are going to want to go home. It is a phenomenon that a kid will be in a very fine, loving foster care home and will work to get home to an abusing parent because he or she is their parent. We have got to work with those families, and we have got to do it in a societal way, in a way in which we create some norms, where it becomes important to be a parent.

We in government, of course, can't mandate how people should run their families. None of us are advocating that. I don't want the Government telling me how to run mine. But we have got to create a way in which we strengthen the commitment as a culture to being good family members.

To that end, we have created a policy by organizing a number of our leading citizens in the county and parents' groups that basically says four things: that if you are going to talk about alcohol, drug abuse, and violence, you can't simply talk about doing that in the schools alone; we are already asking our schools to take care of child abuse, teen suicide, pregnancy; we have more and more asked the schools to imbue values to our children, and it has got to be our responsibility in the home to do that.

I am willing to bet, if you ask your friends, not one of them has had a family dinner with the television off in the last seven or eight days, because we just don't have time. So how the heck are we going to imbue those kids with values if we don't take the time to talk to them?

We have a culture that is going too fast; how does one take time out? So we can't ask the schools to do it alone. When you have a $100 billion illegal drug market in the United States—we spend $100 billion on drugs in the United States, if the numbers are accurate, that is not a children's problem; it is the adults buying those drugs. We have got to get to adults, and the way to do that is in the work place and through the media.

Alcohol is the number one consumed beverage on television. The average child will see 18,000 murders before the age of 18 on television. It is the television that is imbuing values today more than we are as parents.

So we have to work, and this policy calls for working toward creating a positive environment in the home, the school, and the community; for including private enterprise, private business, and our social organizations. Schools, parents' groups, youth groups, county services, and community agencies, law enforcement, all have got to be working together basically at the cellular level—that is, at the local community level—literally little Soviets, if you will, where people are getting organized to attack this problem at the local level. If we try and do it on high, it won't work.

attack this problem at the local level. If we try and do it on high, it won't work.

In addition, folks here have said that we have to work at the early intervention stage. I am working in Contra Costa County. We are a Prop 13 State. The citizens have made it very, very clear that they are taxed at about, the level they want to be taxed.

My county is growing at 10,000 people per year, and in California that is a slow rate of growth; 10,000 people a year is a slow rate. In some of the larger counties, that number is three and four times that high in numbers of people. So I am working to see if I can get organized politically to see if the citizens would be willing to vote a property tax increase to raise about $7 million for a host of early intervention programs, including respite care for parents, working in the homes with young kids, working in day care, and the like.

I am competing against a sheriff for a new jail and against my boss for a new county hospital, and many other necessary and positive things that have to be done, but it is something that I hope to see taken to the citizens, and I am simply going to ask this question, and I think it might work. People are laughing at me at home, but I think it might. How many of you can honestly say in the last five years and in your own immediate family, or certainly in your extended family, there hasn't been at least one significant alcohol, drug, or mental health problem? When you went to get help, what happened? I think if I can ask those two questions, we will have a chance of seeing that ballot initiative passed.

Congressman Miller has already noted in his opening statements AB-3632 in California. We are attempting to implement Public Law 94-142. In our county alone, I have seen an increase in referrals of 175 additional children who, before that bill was passed, were not part of the mental health system, from the schools. We are not even remotely close to having sufficiently increased funding for staffing to meet that need, but the intent is very positive. These kids, in fact, are very disturbed. They are not psychotic. That is, they don't have significant delusions, but they certainly act in ways that are not social, and we are working hard to see that that bill be implemented.

We are also working very hard to increase conflict resolution panels in our schools all the way down to the elementary level. When kids get into a fight now in Contra Costa County, in most of our high schools and increasingly in our intermediate and elementary schools—well, at least a few of those—we have teams of specially trained mediators—that is, kids themselves, who step in, break up the fight, with no parental, no administrative, or faculty input at all. They set the kids down; they have very specific questions—training, that is. For instance, they never ask the question "Why?" There are lots of things that they do as part of their training. They get the conflict resolved and never have parental involvement, never have adult involvement, rather.

The impact of this program has been significant in reducing truancy and expulsion rates in the involved schools. It has been significant in breaking down the racial cliques, and, most of all, it is teaching the kids that there are other ways to solve problems besides bashing your opponent in, which is what they see on television and what the media portrays daily.

So prevention has got to occur. I don't think in California there will be ever enough dollars to meet the need. We have got to work at getting that basic cellular system, that basic family, to function better. We have got to make parenting the most important part of being part of our culture. Whatever you can do here in Congress to accentuate that, to make all of us aware of it, is critically important. Basically, I am talking about creating mores where the family comes first and our capacity to consume or to demonstrate consumption or the like is significantly secondary.

[Prepared statement of Stuart McCullough follows:]

PREPARED STATEMENT OF STUART MCCULLOUGH, CONTRA COSTA COUNTY MENTAL HEALTH DIRECTOR, CALIFORNIA

In the State of California, during the early 70's, Governor Ronald Reagan significantly reduced the state mental hospital system and transferred responsiblity to the "local level". The local level is, in fact, the county mental health systems. Counties were and are ill-prepared to assume this responsibility. There was very little, if any, political orientation of the local Boards of Supervisors to prepare them for this new and complex responsibility. Suddenly, counties were expected to provide an array (or continuum) of mental health services without any time to prepare an administrative and clinical infrastructure. The result has been chaos, unfulfilled promises and a great deal of bitterness on the part of the mentally ill and their families. To make matters worse, the Governor usurped a substantial portion of the state hospital savings into the General Fund. Therefore, the California community mental health system began significantly underfunded and has continually operated on a poverty basis.

Initially the California mental health system focused primarily on the persistently mentally ill adult. However, over the past ten years a very strong lobby has been demanding that children services be a high priority in all county mental health systems. In Contra Costa County, the mental health system is receiving an ever-increasing number of referrals. It is very important for the Select Committee to know that we are seeing an increasingly disturbed child. Typically diagnosed as borderline personalities, many of these children are violent, have a poor prognosis and come from a very dysfunctional family. A very high percentage of the children are polydrug abusers. We are seeing children from all economic and racial backgrounds. This is reflected throughout the entire State of California.

Other County Departments, such as Social Service, Probation and Special Education, recognize they are working with mental health problems. Increasingly these departments are asking mental health for assistance as they attempt to carry out their respective mandates. All of the above named departments are inundated with kids and all are seeing the quality of services deteriorate under the sheer magnitude of their caseloads.

In California we currently have over 9,000 children placed in group and specialized foster home care. The cost to the State is over $220 million annually. This expense is increasing at the rate of 20 percent per year. In our Probation Department the typical Juvenile Probation Officer is carrying a caseload between 65 and 80 children. There are three outpatient clinics in Contra Costa County that serve children. To date, each is averaging a waiting list of at least 50 children. We find ourselves operating on a triage basis, being sure to take care of the most self-destructive or imminently hostile children first.

In Contra Costa County, like in many other counties around the State, we are forced to have children with placement difficulties on our adult acute inpatient wards. We do this only as a last resort. For the past eight weeks, we have had a 13-year old developmentally disabled girl on our adult ward because we are finding it impossible to locate any program willing to accept her because of multiple mental and health problems.

Certainly an increase in funding for the mental health system for children needs to be a high priority. In addition, we must do something to strengthen the basic family unit whatever its structure; i.e., single parent, both parents working, blended family, etc. One in four children is raised in a family where there is serious alcohol abuse. In a study recently completed at

Mills College, it was determined that one in three girls and one in seven boys will be sexually abused before the age of 18. It has also been estimated that 80 percent of the sexual abuse of children occurs from someone known to them in the home.

In Contra Costa County we are working at a number of levels to attempt to create a prevention system to work in supporting families and head off these problems before they become acute and require the intervention of county services. The County Administrator, Phil Batchelor, has organized two symposiums on the family and created the Family Alliance Foundation to help promote programs in the community that strengthen the family and assist parents in the complex task of raising children in our ever-changing society. These symposiums, attended by over 300 citizens in the County, have brought leaders from the schools, private industry, community agencies and county services together to create a common strategy to support the family.

We have formed a large citizens task force and developed a drug/alcohol and violence prevention policy. This policy stresses that the drug and alcohol problem is first and foremost an adult problem. Estimates are that there is a $100 billion a year market for illegal drugs in the United States. It is not the children buying these drugs; it is the adults. The policy further states that these problems cannot be addressed in the schools alone. Each community must establish a comprehensive prevention group at the local level to inclue private agencies, schools, law enforcement, community service organizations and parent organizations all working together. We need to work with the media, particularly television, to continue the progress they are making toward positive family models. The average child will see 18,000 murders on T.V. before the age of 18. The number one consumed beverage on T.V. is alcohol.

We have asked every school district governing board and City Council in the County to adopt this policy. Our goal is to have every city and school district working within a common framework. The County Board of Supervisors and the County Board of Education have already adopted the policy.

What is the role of government in trying to strengthen the family? Surely it is not our role to tell people how to manage their families. But government, at all levels, should do all that it can to ask people to question their values as they relate to their children and families. We seem to be letting other people imbue our children with values; those being the schools, television and the streets. Somehow there has to be a way for our society to take a break and decide what is really important.

What does fulfill us an Americans? The media tells us it is what we are able to consume. I can tell you from my perspective of a County Mental Health Director that our fulfillment needs to be that our children live in a family that has the following components. The child can articulate a position by the age of 12 against the use of alcohol and drugs; the child lives in a home with at least one parent who is free from the influence of alcohol and drugs; the child is a significant participant in making family decisions; and the child has been imbued with a sense of the spiritual beauty and harmony of this world. How many of us can say that this is our priority in this high-paced technological world we live in? Is it any wonder that our county health and human service systems are inundated and losing ground?

Material Distributed by Stuart McCullough to The Select Committee on Children, Youth and Families:

Letter from Chairperson of Mental Health Advisory Board to the Board of Supervisors

Contra Costa County Health Promotion Policy: Focus on Alcohol/ Drug Abuse and Violence Prevention

Presentation to Advisory Committee on Funding County Services Regarding Proposed Ballot Initiative

Article to Editor of CONTRA COSTA TIMES

CONTRA COSTA COUNTY
HEALTH SERVICES DEPARTMENT

To: Advisory Committee on Funding
County Services

Date: July 14, 1986

From: Stuart McCullough
Assistant Health Services Director
A/DA/MH Division

Subject: Need for Improved Community
Based Alcohol, Drug and
Mental Health Services

Increasingly, the Mental Health system is asked by other county departments, cities, and the State to provide therapeutic services. The Departments of Probation, Social Service, Sheriff and County schools all look to Mental Health to provide critical and essential community-based mental health services to assist them in the successful completion of their respective tasks. In spite of this increasing demand, the Mental Health system has been undergoing a steady decline in available resources. This will be documented throughout the body of this report. Each specific population is described in terms of the needs and service priorities.

In addition, attached for your review are the July 1985 "Mental Health Planning Task Force Report" and the "Drug Abuse Inventory by Region". These reports should prove helpful in understanding the nature and scope of the problems faced by the Mental Health system.

Adult Mentally Disabled Needs and Service Priorities

According to a recent study by the National Institute of Mental Health, at least one out of every four individuals in the nation will suffer from some form of mental disorder during his/her lifetime. Using these national projections, we estimate that during any one-year period, 13 percent of Contra Costa's population experiences a mental disorder ranging from family and individual interpersonal crises to disabling mental illnesses including schizophrenia, manic depression and psychoses. A 1985 needs assessment, "The Mental Health Planning Task Force Report", indicates that there are 10-15,000 adults in Contra Costa County who are severely and chronically mentally disabled.

Until recently, seriously disturbed adults were cared for in State Mental Hospitals. In 1972, a deinstitutionalization process began by reducing the number of beds in State hospitals. It was the intent to pass on to the counties the State savings that resulted from closing these hospitals. This transfer of funds never occurred; instead the funds were transferred to the State General Fund.

In 1960 there were 37,000 State hospital beds available to a total State population of 16 million people. Today there are 5,000 State hospital beds available for a population of over 26 million people. The reduction in State funding available is illustrated below:

1985-86 Projected State General Fund Costs
for State Hospitals at 1960 Bed Capacity

37,000 beds at $150.00 a day (actual number 1960)	37,000 beds $2.025 billion

Actual 1985-86 State General Fund Expenditure
for Mental Health

State hospital beds at $150.00 per day	5,000 beds $274 million
County Mental Health Programs	$447 million
Total	$721 million

1985-86 Projected State General Fund Savings
for Mental Health

At 37,000 beds	$1.3 billion

Today the County is mandated to care for the mentally ill with frighteningly inadequate resources. Contra Costa County, with a population of 700,000 people, has a major gap in our service continuum. For example:

- There are only 18 residential treatment beds in the County for adults.
- In East County there are no residential treatment beds and no day treatment services.
- There are no long-term subacute treatment facilities in the County. At any point in time, over 100 adults are placed in Skilled Nursing Facilities as distant as Merced and Santa Cruz.
- In excess of 100 residential treatment and Board and Care beds have been shut down in the past five years due to lack of funding and financial incentive.

- All outpatient clinics have waiting lists, even for those persons who are seriously disturbed and at risk of psychiatric hospitalization.

- The County Psychiatric Inpatient Service releases seriously disturbed adults to their families or the streets after an average of 6 to 9 days because there are no facilities in which to place them.

The real costs of an inadequate system of mental health care are borne primarily by those who are mentally ill and their families who struggle to care for their children and parents without relief. In addition, neighborhoods and businesses complain about the homeless, disoriented and disquieting individuals who wander their streets.

The Mental Health Planning Task Force Report identifies services required to properly treat our mentally disabled adult population. The most critical needs include: residential treatment facilities in Central and East County, intensive day treatment/day hospital services for individuals discharged from psychiatric inpatient care, socialization and vocational services for the severely and chronically mentally disabled, an in-county long-term secure treatment (Skilled Nursing Facility) facility, a residential treatment program for mentally disabled adults who also abuse drugs and/or alcohol, and additional outpatient and case management staffing.

Children Needs and Service Priorities

Children and adolescents are victims of overburdened mental health services in Contra Costa County. The County has 204,000 children under the age of 19. It is estimated that over 11 percent of the children in public schools have serious emotional problems including drug dependency, emotional and behavioral disabilities, neglect, physical and sexual abuse, and early pregnancy.

In February of 1985, the Mental Health Planning Task Force came together to design a continuum of care for children. After five months of work the continuum was completed and presented to the Board of Supervisors in July. The continuum was prioritized into three levels. These priorities included residential treatment, children and adolescent inpatient units, increasing outpatient capacity, establishing a youth hotline, and increasing crisis services.

Contra Costa County has more children in the State hospitals than any other county except for Los Angeles. There are currently a total of 10 residential beds available for adolescents over 12 years of age with no beds available for those under 12. All of our Mental Health clinics have waiting lists of 20 to 40 children. The Youth Interagency Assessment and Consultation Team alone is booked through the end of August for assessments. Y.I.A.C.T. is a specially designed interdisciplinary team made up of staff from the Social Service Department, the Health Services Department and County schools to assess and treat children and adolescents who are placed out of the home.

Forty to sixty percent of these children have been physically or sexually abused. They are desperately in need of mental health treatment. Many are severely emotionally disturbed, violently acting out, firestarters, and self-mutilators. It is common for those who have been abused to, in turn, abuse others. An increasing number show suicidal tendencies.

Psychosocial stressors for this population are high, including multiple placement failure, multiple hospitalizations, long-term institutionalization, alienation from families, schools and community, and resistance to past therapeutic efforts.

In addition, this type of client either does not have a support system or may be involved with a family that is very dysfunctional; i.e., sexual/physical abuse, murder, rape, hard-core drug abuse and/or alcoholism. This affects the child's entire social system including the child's family and school. Without intervention, these children are at high risk of going to Juvenile Hall, jail, the State hospital or other institutions. Over 70 percent of children seen at our mental health clinics are either wards of the court or referred by the Social Service Department Child Protective Services.

Staff are working at their maximum capacity, some seeing more clients than is appropriate in a given day. As waiting lists expand and referrals continue to increase, pressure on the clinic staff is increasing. Expanded services, new positions, and additional space will certainly reduce waiting lists and lessen pressure on staff, so that they can do a better job with each child. In addition, it will lessen the risk of our children ending up in Juvenile Hall, jail, the State hospital or the streets.

The demand for services gets greater while our resources continue to diminish. We are seeing a significant number of children who are severely disturbed at a younger age. Our intent is to keep families together, create therapeutic avenues to foster reunification between children and their parents, and alleviate the pressure on an overburdened system.

Drug Program Needs and Service Priorities

Drug abuse has reached epidemic proportions in California and Contra Costa County. For example, testimony presented to the Select Committee on Narcotics Abuse and Control of the United States House of Representatives at a January 1986 hearing in San Diego cited an increase of more than 400 percent in emergency room mentions and autopsy mentions involving cocaine between 1980 and 1984. In May of 1986, the California Attorney General's Commission on the Prevention of Drug and Alcohol Abuse stated, "Given the awesome dimensions of the problem - the social, health and economic costs of drug and alcohol abuse - we conclude that this problem is, indeed, an 'epidemic', as many of the witnesses before the commission testified." Other indications of this growing problem abound. AIDS is being spread by drug addicts through needle-sharing; pregnant addicts/abusers are passing dependency to their unborn children; and drugs are increasingly more accessible on campus as indicated in surveys of school children and other members of the education community.

New synthetic, highly dangerous (designer) drugs are appearing every day and are readily available. Recently this County hosted a presentation by a representative from the State Department of Alcohol and Drug programs on the new "designer drug" trend. We have a particular problem in this area. This is a phenomenon in which local street chemists have been able to fabricate new compounds of drugs in clandestine laboratories on a made-to-order basis for individuals who can afford them.

The epidemic of human suffering resulting from drug abuse has far outstripped available county resources to effectively address this problem. In fact, drug programs are now in a position of having to triage patients based on the limited availability of funds to provide services. For instance, there are currently no outpatient services available for adult drug abusers for Central and East County. As a result, many county residents are not able to receive drug treatment services when they desperately need/want these services. The County Drug Abuse Advisory Board is aware of the serious gaps in the system and is continually examining better ways with which to provide quality services.

In 1985, the Contra Costa County Drug Program Administration conducted a needs assessment as part of the Annual Drug Abuse Plan. This Plan and Needs Assessment made the following recommendations as to serious unmet needs in the area of drug abuse services.

(1) Establish an 18-bed residential treatment center for adolescents. It is anticipated this would allow for the diversion of approximately 50 youths from the juvenile justice system.

(2) Establish a short-term, six-bed residential treatment program for women with children. It is anticipated this would preclude the need to place approximately 25 children in foster homes or shelters because these children would be able to stay with their mothers during their recovery period.

(3) Increase outpatient counseling services. The unmet need is particularly acute with respect to the needs of adults and families.

The attached study "Drug Abuse Patterns in Contra Costa County, 1980-85" outlines what the drug abuse trends are in the various regions of the County for adults and adolescents.

Alcoholism Program Needs and Service Priorities

In Contra Costa County, we have been pioneers in the State in bringing about a complete change in the method of treating alcoholism. We have changed the continuum of services from the County Farm, the Hospital and Napa State Hospital to a regionalized comprehensive continuum of community-based contract and county operated programs. This has resulted in a cost benefit ratio of six to one and an ability to serve approximately four times the number of people.

One indication of the success of this system is the fact that all our programs are intimately involved with Alcoholics Anonymous which has grown from 41 to 181 meetings a week. In short, funding alcohol programs is simply good business. Most of the individuals served get better, go back to work, and become taxpayers.

Nevertheless, there are many remaining unmet needs. Nineteen percent of our Nation's youth have problems with alcohol. One out of four children live in an alcoholic family. One out of every three individuals in a recent Gallup Poll indicated that alcohol is a source of problems in their families. A 1984 study of the Research Triangle Institute indicated that the cost of alcohol problems to the United States was $120,811 billion. Approximately 50 percent of our Criminal Justice budget is expended for alcohol-related problems. Approximately 33 to 50 percent of our health care costs are attributable to alcohol.

Specialized alcohol programs for youth not available:

° Thirty-five residential beds for adolescents as alternatives to Juvenile Hall and the Byron Boys' Ranch.

° Expansion of the Friday Night Live Program to every school in the County.

° Counter-media advertising depicting what alcohol is doing to our society.

Specialized alcohol treatment for women not available:

° One 20-bed social rehabilitation model detox facility.

° Twenty-five residential beds to reduce waiting lists.

Specialized alcohol programs for men not available:

° One hundred residential beds to reduce current waiting lists.

° Fifty-four social model detox beds to be used in lieu of taking drunk drivers to jail and thereby reduce overcrowding in the jail system.

The Alcohol program faces some strong challenges. Our programs have long waiting lists and strained budgets. We are constantly trying to find new and better ways to address our problems. Public safety and prevention are increasingly becoming part of our treatment program. One of these, Friday Night Live, is directed toward teenagers and is sponsored in conjunction with the Rotary Foundation. Over the next several years we hope to effectively reach the majority of the high school students regarding the danger of driving under the influence of alcohol.

Geriatric Program Needs and Service Priorities

There are 110,000 people in Contra Costa County over 60 years of age. This is a population which often requires increased mental health services. Currently the fastest growing problem facing our geriatric treatment system is the increasing rate in the diagnosis of Alzheimer's disease. Twelve to fifteen percent of our citizens, over 65 years of age, suffer from this disease. Forty percent of the people over 80 are diagnosed as Alzheimer's patients. By the year 2000, the number of people over 85 in Contra Costa County will have tripled.

At a recent meeting of retired Contra Costa County employees, a large number were concerned about the availability of services for their parents. It is indicative that our retired citizens are now concerned about the care of their parents, who have long since retired.

Currently, we are supporting the Health Services Department plan to create a 30-bed locked skilled nursing component to Merrithew Memorial Hospital. We are also working toward creating a more home-like program for our Alzheimer's population in a rural area of the County. This will allow sufficient space and security to humanely care for these people.

Conclusion

It is highly likely that every citizen in this County, over the next five years, will have some contact within his/her extended family with the Alcohol, Drug and Mental Health system provided by the Health Services Department. The simple reality is that the demand continues to increase for all specialized populations. There is no indication that this increasing demand will subside. The available resources continue to diminish in relation to the ever growing needs. A ballot initiative in support of community-based mental health, alcohol and drug services would be a major step toward redressing this problem and contributing toward a just and humane society for all our citizens. It is important to note, because of the cost of the care, only the very rich can afford to pay privately for treatment, especially if the problem is chronic.

SMc:vn

Attachments

cc: Phil Batchelor
Mark Finucane
Mental Health Advisory Board
Alcoholism Advisory Board
Drug Abuse Advisory Board

Health Services Department
ALCOHOL/DRUG ABUSE/MENTAL HEALTH DIVISION
2500 Alhambra Avenue
Martinez, CA 94553
(415) 372-4416

COMPREHENSIVE STRATEGY FOR THE PREVENTION OF ALCOHOL/DRUG ABUSE AND VIOLENCE IN CONTRA COSTA COUNTY

BACKGROUND

In the spring of 1986, a group of citizens representing various segments of the community convened to improve upon alcohol and drug prevention efforts for youth in Contra Costa County. After numerous meetings, this group developed into a formal task force whose focus evolved to include the concept of health promotion and concerns about abuse and violence. It was agreed that achievement of this involved both an overall health promotion effort and specific prevention strategies targeting alcohol/drug abuse and violence.

Following the lead of Attorney General John Van de Kamp's Commission on Alcohol and Drug Abuse, the Contra Costa County task force embraced the concept of the comprehensive prevention plan outlined in the Commission report. Adapting several elements of the Attorney General's report, the task force developed a comprehensive health promotion strategy focusing on prevention of alcohol/drug abuse and violence in Contra Costa County. The objectives include:

- Adoption of this policy countywide by the Board of Supervisors, City Councils, the Board of Education and individual school boards;
- Development of prevention action plans by each of these constituencies delineating the specific steps they will take in their communities; and
- Development by the task force of a compilation of state-of-the-art prevention methods and community-based resources to assist each community in developing its individualized prevention plan.

For more information call the Prevention Program at 372-2511.

2-4-87

CONTRA COSTA COUNTY HEALTH PROMOTION POLICY:

FOCUS ON ALCOHOL/DRUG ABUSE AND VIOLENCE PREVENTION

FOREWORD

Alcohol/drug abuse and violence are problems which have become all too familiar to our society, impacting our health and quality of life. As citizens of Contra Costa County, we are concerned with the prevalence of these problems within our community, particularly among our youth. We believe that the prevention of alcohol/drug abuse and violence is possible through the cooperation of all members of the community in a comprehensive health promotion effort.

Attorney General Van de Kamp's Commission on the Prevention of Alcohol and Drug Abuse calls for a comprehensive plan of prevention to combat alcohol and drug abuse among youth. Consistent with this report, we propose a health promotion policy which identifies and mobilizes community actions directed at the prevention of alcohol/drug abuse and violence in Contra Costa County.

ELEMENTS OF A COMPREHENSIVE PREVENTION STRATEGY

1. THE OVERALL EFFORT SHOULD BE COMPREHENSIVE, COORDINATED AND INTEGRATE ALCOHOL/DRUG ABUSE AND VIOLENCE PREVENTION ACTIVITIES.

1.1 Using multiple methods and strategies is essential as research shows that no single approach alone is successful.

1.2 Alcohol/drug abuse and violence prevention are viewed jointly as they have common elements which make them responsive to broad-based preventive approaches. With regard to treatment, they are distinctly different and require separate treatment modalities.

1.3 Coordination of resources and effort promotes efficiency, reducing duplication and fragmentation. Systematic methods to inventory and share expertise/information should be enhanced. Utilization of existing community agency expertise is essential. Many sectors of the community have developed programs and/or policies which focus on alcohol, drug abuse or violence. These efforts should be recognized and used as an important basis from which to build a comprehensive effort.

1.4 All prevention efforts must reflect the cultural and ethnic diversity found within each jurisdiction.

2. ALL SEGMENTS OF THE COMMUNITY SHOULD BE INVOLVED IN ALCOHOL/ DRUG ABUSE AND VIOLENCE PREVENTION EFFORTS.

2.1 Youth must be involved as leaders in prevention efforts and should be included at each stage of the development and implementation of the overall prevention strategy and individual action plans.

2.2 Parents, teachers, community service providers, health professionals, law enforcement, religious groups, business, unions and government all have a critical role to play; building upon each other's efforts translates into community programs, campaigns and political action which are mutually reinforcing.

2.3 Law enforcement and regulatory officials must continue to enforce laws governing alcohol sales and possession by minors, reduce availability of drugs by arrest and seizure and actively enforce laws governing violent behavior. Additionally, they are in a critical position to participate in community-wide prevention efforts, to educate the community about substance abuse and violence, and to promote positive alternatives to them.

3. AN EFFECTIVE PREVENTIVE EFFORT TO REDUCE THE INCIDENCE OF ALCOHOL/DRUG ABUSE AND VIOLENCE REQUIRES WELL-CONSTRUCTED STRATEGIES IN SCHOOLS, WORKPLACES AND THE MASS MEDIA.

3.1 Schools: Prevention curriculum and activities should be infused into all appropriate aspects of the school's social and learning environment. Students, parents, faculty, administrators and community members must be actively involved in implementation and evaluation of each school's prevention program. In developing new programs and curriculum, or strengthening existing ones, emphasis should be placed upon age-appropriate activities at every grade level.

Program elements might include: physiological and psychological effects of alcohol and drug abuse; improving self-esteem; refusal skills; coping and communication skills; decision making; identification of personal, social and environmental risk factors for substance and physical abuse; wellness concepts and positive alternatives; pre- and early-parenting education; and conflict resolution.

Because of their access to youth on a large scale and their role in the education process, schools are crucial to prevention efforts. Steps must be taken to create a positive overall school environment. Joint planning and coordination between community-based agencies, schools and law enforcement is an essential part of successful school-based prevention efforts.

3.2 Workplace: Prevention programs must focus on adults as a primary target. As parents and community members, adults influence the attitudes and behavior of youth. Additionally, adults need services and information to help prevent their own participation in alcohol/drug abuse and violence. The workplace is the best site for personally reaching adults and employers should use it to provide information, resources and alternatives. Unions have an important role to play in this effort.

3.3 Media: The media's help is needed to portray positive alternatives to alcohol and drug abuse and to reinforce school and community efforts. It is crucial for the community to communicate to the media its desire to see news and information which depict the health, social and economic costs of alcohol/drug abuse and violence. In certain circumstances, producers of television, radio and music videos must be encouraged to do a better job of self-regulation to reduce their apparent glorification of alcohol/drug use and violence.

3.4 Information, Materials and Training: Individuals involved in developing and providing prevention services need information and training about current prevention concepts, methods, skills and resources. Community agencies are a vital component of this effort. Particular emphasis should be placed upon the training provided teachers, law enforcement, health and human service personnel.

3.5 Needs Assessment and Evaluation: Needs assessments and evaluations must be an integral part of all prevention strategies and program designs. Data from needs assessments will enable the particular community/school to best match specific prevention techniques and action plans with local needs. Ongoing evaluation is critical to assure that plans continue to accomplish the goals for which they were initiated.

4. IMPACTING ALCOHOL/DRUG ABUSE AND VIOLENCE DEPENDS UPON CREATING A POSITIVE ENVIRONMENT THROUGHOUT THE HOME, SCHOOL AND COMMUNITY.

4.1 Strengthening of families and their involvement in community prevention efforts is crucial. Parents must be aided in the increasingly difficult task of successfully raising children in our complex and ever-changing society. They should be provided with information and resources to help them accomplish this. Assistance in enhancing skills as role models and maintaining positive relationships with their children should be made available to parents. All efforts targeted toward parents must take into account the diversity of family structures common to Contra Costa County.

4.2 Individuals must be provided with positive alternatives to alcohol/drug abuse and violence. Examples of alternatives should include programs which develop conflict resolution skills, promote substance-free recreational activities and establish community centers. The importance of a promising future, particularly meaningful employment opportunities, cannot be overemphasized.

4.3 All efforts must be designed with careful attention to reducing the stigma commonly associated with people seeking help with alcohol/drug abuse and violence.

CONCLUSION

The effort to prevent alcohol/drug abuse and violence will require a strong commitment from all sectors and members of our community. With the close cooperation of parents, educators, youth, business, unions, government, health professionals, community groups, media, service organizations and law enforcement we can reduce the occurrence of these problems in Contra Costa County.

SPECIFIC ACTION BY ELECTED BODIES

In adopting this policy, the ____________________________________ agrees to the following:

To promote the elements described above;

To direct the ____________________ to develop and implement an Action Plan by ____________________ (date) to carry out specific elements of a prevention plan;

To annually review this policy and Action Plan to make revisions and assure that all important community elements are working together; and

To function as a model employer with our own employees by applying the appropriate elements of this policy to our workplaces.

STATEMENT OF ENDORSEMENT

We, the Board Members of ________________________________ hereby endorse the above policy. In so doing we are agreeing to the concepts put forth in the text and are supporting the actions of the elected officials which designate specific action steps within their jurisdiction.

Signed: Date:

______________________________ ____________________
Name

____
Title

____
Agency Address

____
Phone No.

Please return this page to:

Prevention Program
1111 Ward Street
Martinez, CA 94553
372-2511
Attention: Ellen Goodman

CONTRA COSTA COUNTY
MENTAL HEALTH ADVISORY BOARD
2500 ALHAMBRA AVENUE
MARTINEZ, CALIFORNIA 94553
Phone (415) 372-4395

TESTIMONY TO BOARD OF SUPERVISORS
Dennis Lepak, Chairperson
May 12, 1987

Madame Chair, Supervisors, Mr. Christen, fellow concerned citizens. The Mental Health Advisory Board welcomes this opportunity to testify in support of the Fiscal Relief Plan as proposed by the County Supervisors Association of California.

Over the past few years the members of the Mental Health Advisory Board have become concerned, appalled, and more recently, dazed, by the ever increasing burden of responsibility placed on the Mental Health System without the necessary funding to implement mandated services.

A few of these underfunded services are: Services for the mentally ill homeless; augmentation services, under SB155, for Board and Care Homes; conditional release programs for mentally disordered offenders and mental health services for emotionally disturbed children under the mandates of AB3632, perhaps the cruelest legislative hoax yet.

I could quite easily take the entire morning telling you of specific waiting lists, lack of beds, and non-existent yet necessary services. I will mention only a few. This is a County whose citizens command enormous resources of power, influence and personal wealth. But, if you are one of the less privileged adults in this county and are forced by circumstances to beg for help at a public community mental health clinic you could be placed on a countywide waiting list with 80 others. Apallingly, if you are a child the wait is longer. Today more than 100 children line up to wait months for outpatient services they desperately need now. What kind of a society refuses services to suffering children waiting while spending millions on regional parks, courthouses, and prisons?

I am not going to take your valuable time relating "horror stories". I could take the rest of the week telling you of sodomized, raped and beaten children, many of whom are contained, three youngsters to a sweltering, 96 degree, unventilated 10 by 8 room in our Juvenile Hall. Very disturbed children and adolescents are in Juvenile Hall because there are no humane facilities available to them. Last year 56 children were placed in our County run acute wards and mingled with adult patients. Children as young as 8 are placed on J-Ward with psychotic adults. Often even this inappropriate alternative is unavailable for children who Mental

Health Staff at Juvenile Hall are recommending be immediately hospitalized. I must repeat this, I think it should be emphasized. **Children suffering acute mental illness are being segregated and locked down in county detention facilities under conditions inferior to local facilities housing adult prisoners convicted of violent felonies.**

I feel I must also tell you of the plight of Mental Health line workers who serve these children and unfortunate adults. They also suffer. They are asked each year to attend to cases of greatly increasing severity in ever increasing numbers. Workers suffer stress related illnesses, glaze over and they become emotionally depleted. Individually they are exploited by the system in direct proportion to their degree of caring.

Who is responsible? We all are. And,if we are all responsible then we can all point our fingers and share the blame. and no one bears the ultimate burden or responsibility.

Some of us must be more responsible than others of course. Line workers who remain silent without protesting and organizing are responsible. Department managers who give up and stop demanding adequate funds in their budgets are responsible. Local political leaders who do decline to look the suffering in the face and then educate their constituents are responsible. And, of course, our favorite responsible parties, the ones we point to this morning, the Governor and Legislators who wheel and deal in Sacramento, far from the screams of pain and the tormented children.

Ultimately, we the voters are responsible. We must demand a change of priorities. We make that demand of and through you today.

Health Services Department
ALCOHOL/DRUG ABUSE/MENTAL HEALTH DIVISION
2500 Alhambra Avenue
Martinez, CA 94553
(415) 372-4416

March 26, 1987

Ernest E. Hines, Editor
CONTRA COSTA TIMES
2640 Shadelands Drive
Walnut Creek, CA 94598

Dear Mr. Hines:

As one of the people responsible for providing alcohol, drug and mental health services in the public sector, it is difficult not to sound like Chicken Little. The needs are great and the resources are few. To us it feels like the sky is falling, albeit incrementally. Twenty-five years ago there was no perceived need for a mental health treatment system. Why is the need so great today?

The American family has undergone a profound change in style and structure since World War II. During this period few cultural norms or rules have been established where we hold each other accountable for how we manage our families. The automobile has become an indispensable part of our lives, and we have become so mobile that the nuclear and extended families have begun to break down. The participation of grandparents, aunts and uncles in the raising of children is no longer the norm. Parents are often raising children by themselves. Women, following World War II, did not want to go back to being solely homemakers and have opted to be active and full participants in the workforce. Currently, over 50 percent of the mothers of preschool children work. Thirty years ago it was 15 percent. The high rate of divorce has put a tremendous strain on single parents who are trying to raise their children in such isolation that it can be profound. Only 68 percent of American children live with both biological parents.

These difficulties of the family have been exacerbated by other cultural trends. Our society is dominated by television and other electronic media. It drives our politics and has become the primary source for the establishment of our values. The result is that we determine our worth by what we are able to consume. We are constantly told that sex appeal is the key to

A-371 Contra Costa County

success. We are becoming immune to violence and abuse. The average child will see 18,000 murders on television before the age of 18.

Subtlely we are turning into a two-dimension culture where our primary link to each other is through a 19-inch screen where there is literally no depth. The norm for children watching television is at least two and one-half hours per day. This consumption-driven televising process, combined with our historical wealth, has lead to a narcissism which is creating a natural breeding environment for the consumption of alcohol and other drugs. We are consuming these substances at record rates with extraordinarily destructive consequencs. It is estimated that the total cost to the United States in health care, insurance losses, absenteeism and lost productivity due to alcohol abuse is 120 billion dollars. In 1985, estimates are that the illicit drug market in the United States was in excess of 100 billion dollars.

What has been the result? Our culture is declining. We fear for what the future portends and with good reason. Parents are afraid to take their eyes off their children every place they go, even in the supermarkets. We have a society where violence is commonplace. It is becoming the norm. In 1970, there was not a single battered women's shelter in the United States. Today there are 1100.

What can be done? There must be an awakening on the part of the citizens of the United States that we are basically out of control of the pace and content of our lives. That it does not matter if we drive a BMW, dress in designer jeans or live in a 3,000 square foot house. What matters is that our children advance in grade level each school year. Homework must come first and we must be there to help with the difficult problems. Our children must participate in making decisions for the family. Our children must have a sense of the spiritual beauty and goodness of this world. Our children must have parental models who are free from the abuse of drugs and alcohol.

The family is the basic building block of our society and, as a cultural norm, it must be paramount in relation to our careers and attending status symbols.

Government will remain roughly constant in size and thus will diminish in proportion to the growth of population. This will translate into government becoming more of a crisis health and welfare system. This is certainly true for the public mental health system. We will not be able to continue to provide the already severely limited psychotherapeutic services that the citizens have come to expect. That is why we helped form the Family Alliance, first envisioned by County Administrator Phil Batchelor. We are supporting this and other prevention programs that will help to form networks to support healthy families. John Naisbitt, in his book Megatrends, indicates that networking is the key to the success of most human endeavors. Networking basically means getting organized by linking and forming coalitions. Our mobility, television, consumerism and substance abuse can all be a hindrance to human linkage. We must create norms or expectations for each other where we demonstrate we are in control of these factors in our lives, and that we recognize our children are a reflection of ourselves, our families and our culture.

Sincerely,

Stuart McCullough
Mental Health Director
Contra Costa County Health Services Department

SMc:vn

Chairman MILLER. Thank you.

Marilyn.

STATEMENT OF MARILYN MENNIS, VICE PRESIDENT OF SERVICE ADMINISTRATION, PHILADELPHIA CHILD GUIDANCE CLINIC, PHILADELPHIA, PA

Ms. MENNIS. Thank you, Mr. Chairman.

I am Marilyn Mennis, vice president of the Philadelphia Child Guidance Clinic. I am here to talk about some services that do exist which are alternatives to institutionalization of our emotionally troubled children and adolescents, based on my own experience as the service administrator at the clinic.

A little bit about the Philadelphia Child Guidance Clinic. We were founded in 1925. We are a nonprofit, comprehensive mental health organization serving children and adolescents. The Clinic is nationally known for its family systems approach which recognizes that a child does not live in isolation from his or her family and community environment and that aspects of that environment must be included in treatment.

For kids who have no immediate family, extended family or substitute care givers, such as residential counselors or foster parents, are included in the treatment program. Other aspects of the child's environment such as school and social services are also critical aspects of the child's treatment.

The Clinic provides psychiatric hospitalization to about 400 youngsters a year and a range of outpatient and community programs for 2,000 children and adolescents and their families. Our 38-bed hospital admits youths between the ages of 7 and 24, with an average length of stay of about 30 days, and that is about one-third the national average for children and adolescents. Half of our patients are on Medicaid.

We have two apartment units in our hospital where children under seven can be admitted with their families, because we do not believe it is appropriate or desirable to separate a child that young from the family even for a short 30-day period. Our crisis and emergency service sees about half of the child and adolescent emergencies in the city of Philadelphia, about 500 a year. On the outpatient side, we provide diagnostic assessments and individual, group, and family therapy.

For most children whose difficulties are episodic, psychiatric outpatient services are appropriate, but for the seriously disturbed youngster, traditional psychotherapy is not particularly effective or sufficient. Part of what I want to say here is that we need to stop trying to fit round pegs into square holes or square pegs into round holes and try to make the services fit the needs of the kids. I would like to talk today about a couple of our new alternative programs for these very seriously disturbed youngsters.

In 1982, in the city of Philadelphia, there were less than 200 emergency room visits by children and adolescents, psychiatric visits. In 1987, five years later, the figure is expected to exceed 1,000. That is a 500 percent increase in five years. On any given day in Philadelphia, there are 2 to 15 youngsters awaiting a hospital bed which is not available for them. I would like to tell you a little bit about these kids.

Half of the emergency room visits result from suicide attempts or suicidal behavior, including children as young as nine and ten years of age. Not too many weeks ago, we had two nine-year-olds who had made a suicide pact that was considered serious enough that those two children had to be hospitalized; they were considered to be at risk.

The youngsters we see are more than ever before chronically disturbed with acute symptomatology. Many seriously mentally ill young adults experience their first episode in their teens, and I think we are seeing a lot of those kids right now. Increasingly, these children are without nuclear families, which means that Child Welfare is involved, and placement becomes paramount and seriously problematic.

One of the factors that extends length of stay in a psychiatric hospital for children is the need for out-of-home placement and the difficulty finding that. There are more emergency admissions, more multiple hospitalizations, so that, in general, we are seeing a more disturbed child with fewer family and financial resources.

In order to treat these difficult-to-serve kids more effectively, and with the initiative, creativity, and support of the county mental health authority, we began to develop alternative community-based programs designed to reduce numbers of admissions to community and State hospitals, to shorten length of stay, and to keep youths at home or at least in the community.

Our Social Rehabilitation Program is an intensive outreach and home-based program whereby an experienced clinician spends anywhere from 10 to 50, or more if necessary, hours per month with the patient and family in their own home. The clinician's work may include getting housing for the family, getting an appropriate school placement for the child, obtaining health care for the child, court issues, relationships with extended family, as well as providing therapy to the child and to the family. We will work to resolve any family, community, or social service problem that will help that family stay together, keep that child out of the hospital.

The program includes 24-hour emergency services and a home visiting team whereby a child care worker goes to the home when there is a crisis and will remain with the family until the crisis can be stabilized. That could be two hours, it could be two days, whatever it takes. It is an intensive intervention program.

In the first year of operation, we served almost 100 children and adolescents; 15 of those 100 had been in a long-term-care State hospital, 42 had been hospitalized in an acute-care setting at least once, and many of those kids more than twice. Most had multiple emergency room contacts, and their hospitalizations were often on an emergency basis.

During the first year of the program, not one child had to go into the State hospital. Only 8 of the 100 had to be hospitalized in an acute-care setting, and these were planned admissions with well-defined follow-up back in the community, back with the family. This contrasts sharply with the history of emergency room episodes and emergency hospitalizations.

The second program I would like to talk about is our Host Home Program, which is similar in intensity to the Social Rehab Program I just described except that it is for youngsters who are unable to live with their natural families. The ability to provide them with a therapeutic foster family means that institutional care is avoided.

In addition to clinical work that we do with the child in the host family, the program maintains the involvement of the natural family as an integral part of the child's treatment with the goal that possibly this child may be able to go home. The program provides a trainer-supervisor to the host home family, it provides a case manager to the child and the family, and it provides a therapist to the child and the family. This program, I would like to mention, is a jointly funded program between the child welfare system and the mental health system.

These programs result not only in an improved quality of life for kids but in significant cost reductions, and I would like to mention some numbers briefly. A year at a State hospital for a child in Pennsylvania is over $100,000. The Host Home Program runs about $35,000 a year for one youngster per year, and, by the way, we consider host home parents members of our treatment team and we pay them commensurate with their professional role in that program.

The Social Rehabilitation Program, where the child lives at home but receives intensive services, costs about $6,000 to $7,000 a year for one youngster. So there are significant cost differences between programs.

I would like to mention briefly a couple of other programs that we have. In 1981, we started a pilot project to provide a family-based treatment program for adolescent sex offenders. I think it is the only one in the State of Pennsylvania and is also an intense program. It is not an hour a week of therapy; the adolescent is seen, the family is seen, the adolescent is in a group, the parents are in a group. It is really an intensive program. This program often substitutes for incarceration for the children in it and facilitates early release of incarcerated youths to bring them back to their families.

The fourth program is new in Pennsylvania as well and is a mental health service that we established at our Youth Detention Center for Preadjudicated Youths who basically had minimal mental health services prior to this program. The program is designed to prevent inappropriate hospitalizations by providing onsite psychiatric assessment and treatment before crises erupt which necessitate inpatient care.

We also provide a preschool program for children with mentally ill parents or parents who are drug and alcohol abusers.

The county of Philadelphia also supports a number of other alternative services, including crisis specialists, therapeutic group homes, and intensive case management services. The availability of all these programs has resulted in a significant reduction in the number of Philadelphia children and adolescents in the State hospital, but it is not enough. Every new program fills up immediately, new beds fill up immediately, and the continuum of services is not complete.

I would like to make a few recommendations based on our experience with kids' needs. I think we need to expand and replicate the kinds of programs that I have described here and which the city of Philadelphia is supporting and the Clinic is providing.

We need comprehensive crisis intervention services that are designed for children and adolescents and their families, not for adults but for kids. That should include mobile teams who could travel to the site of the crisis where the youngster is. We need more nonhospital therapeutic residential alternatives for children who are mentally ill and also dependent and unable to live at home. We need more short-term psychiatric hospital beds, including secure beds, particularly for public sector patients or publicly funded patients, and particularly for adolescents.

We need family support services. The parents in the first panel spoke about this, and it is probably one of the most lacking areas. We need respite care, baby-sitting, homemakers, parent training, recreation, vacations, anything that can help a family cope more effectively and keep their kids with them at home.

My final comments express both my frustration and my hope at being a provider of and an advocate for children's mental health services. There are some nights at the Philadelphia Child Guidance Clinic when we have four or five suicidal or out-of-control kids in our emergency service who need to be hospitalized and there are no beds anywhere in the city for those youngsters.

In 15 years of examining policies, procedures, laws, and regulations promulgated by city, State, and Federal Government, my assessment has been, more often than not—and if you will excuse me for being flip—oops, they forgot the kids. I am pleased to note that in the Congress there is a committee of representatives who have made a commitment to children and adolescents, including those with mental health problems, and I appreciate the opportunity to help you with your important work.

Thank you.

[Prepared statement of Marilyn Mennis follows:]

PREPARED STATEMENT OF MARILYN MENNIS, VICE PRESIDENT OF THE PHILADELPHIA CHILD GUIDANCE CLINIC, PHILADELPHIA, PA

Mr. Chairman, members of the Select Committee, Ladies and Gentlemen. I am Marilyn Mennis, Vice President of the Philadelphia Child Guidance Clinic. Thank you very much for inviting me to testify before you today.

Two years ago this Committee held hearings on Mental Health Care for Adolescents in which the primary focus was the increasing use of hospitalization for adolescents. Last September hearings on Children in State Care mainly addressed institutional care. In both hearings, speakers alluded to the need for community alternatives to institutional care. I am here today to talk about some of those alternatives for our emotionally troubled children and adolescents based on my experience as Service Administrator at the Philadelphia Child Guidance Clinic.

Founded in 1925 as one of seven demonstration clinics in the United States, we are a comprehensive mental health organization serving children and adolescents. The Clinic is nationally known for its family systems approach which recognizes that a child does not live in isolation from his or her environment and that aspects of the environment must be included in treatment. A child's primary environment is the family, and Clinic therapists work extensively with family members to enhance relationships and interactions. For children who have no immediate family, extended family or substitute care givers such as residential counselors are included in treatment. Other aspects of the child's environment, such as school and social services, are also critical aspects of the child's treatment.

The Clinic provides both psychiatric hospitalization and a range of outpatient and community programs. It is also an academic teaching and research institution, serving as the Division of Child and Adolescent Psychiatry of the University of Pennsylvania. Our 38 bed hospital admits youths aged 7-24 with an average length of stay of about 30 days - one third the national average. We have two apartment units in our hospital where children under 7 can be admitted with their families. Our crisis intervention and emergency service sees half of the child and adolescent emergencies in Philadelphia, about 500 per year. On the outpatient side, we provide diagnostic assessments and individual, group and family interventions.

However, today I want to talk about our relatively new alternative programs for very seriously disturbed youngsters, designed to keep these kids out of hospitals and in their communities with their families. In 1982 in Philadelphia, there were fewer than 200 emergency room visits by children and adolescents. In 1987 this figure is expected to exceed 1,000. I would like to tell you about these youngsters. Half of these visits result from suicide attempts or suicidal behavior including children as young as 9 and 10 years of age. We are finding that the children we see are, more than ever before, chronically disturbed with acute symptomatology. Increasingly they are without nuclear families, which means that child welfare is involved and placement becomes more paramount and problematic. One of the factors which extends length of stay in a psychiatric hospital for children is the need for out of home placement. There are more emergency admissions and more multiple hospitalizations. The proportion of Medicaid and indigent patients is increasing. In general, we are seeing a more disturbed child with fewer family and financial resources.

In order to more effectively treat these difficult to serve youngsters, and with the support of the County Mental Health authority, we began to develop alternative community based programs designed to reduce the numbers of admissions to community and State Hospitals, shorten lengths of stay, and keep kids at home or at least in the community. I would like to tell you about four such programs.

The Social Rehabilitation Program is an intensive community and home based program, whereby an experienced clinician spends from 10 to 50 or more hours per month with the patient and family in their own home. The clinician's work may include housing for the family, an appropriate school placement for the child, court issues, relationships with extended family, etc., as well as providing therapy to the child and family. We work to resolve any family, community or social service problem which will help that family stay together and keep the child out of the hospital. Emergency services are available 24 hours a day. The program includes a "home visiting team", in which a child care worker goes to the home when there is a crisis and remains with the family until the crisis can be stabilized - which could be from 2 hours to 2 days. In the first year of operation we served almost 100 children and adolescents. Fifteen had been in a long term care State Hospital. Forty-two had been hospitalized in an acute care setting at least once, many more than once. Most had multiple emergency room contacts. During the first year, not one child had to return to the State Hospital. Only eight had to be hospitalized in an acute care setting; all were planned admissions with well defined follow-up. This contrasts sharply with the history of emergency room episodes and emergency hospitalizations.

Our Host Home Program is similar in its intensity to the Social Rehabilitation Program, except that it is for children who are unable to live with their natural families. The ability to provide them with a therapeutic foster family means that institutional care is avoided. In addition to the clinical work with the child in the host family, the program maintains the involvement of the natural family as an integral part of the child's treatment. The host home parents receive intensive training and ongoing supervision. They are considered to be members of our treatment team and are paid consistent with their professional role.

These alternative programs result not only in an improved quality of life for the children, but in significant cost reductions. A year at a State Hospital for a child in Pennsylvania is over $100,000. The Host Home Program runs about $35,000 for one youngster per year. The Social Rehabilitation Program costs about $6,000-$7,000 per year for one youngster.

The two other programs I would like to briefly mention serve children who are emotionally disturbed and delinquent, dependent or neglected.

In 1981 we began a pilot project to provide a family based treatment program for adolescent sex offenders. The program includes individual counseling, weekly family sessions, and adolescent and parent groups. This level of service intensity lasts six months to a year, with continued follow-up. Active participation of the adolescent and his family often substitutes for incarceration. The program is also designed to facilitate early release of incarcerated youths to bring them back to their families.

Last year, for the first time in Philadelphia, a mental health service was established at the youth detention facility for preadjudicated youths. The program is designed to prevent inappropriate hospitalizations and to obtain psychiatric treatment when needed. It provides on-site psychiatric assessments and individual and family interventions and includes training of detention center child care workers.

These are examples of some of the innovations in community based mental health services for children. The Philadelphia County mental health authority also supports several other alternative services including crisis specialists and therapeutic group homes. The availability of all of these programs has resulted in a significant reduction in the number of Philadelphia patients in the State Hospital for Children. But it is not enough. Each new program fills up immediately and the continuum of services is not complete. Based on our experience in Philadelphia, I would like to make these recommendations:

1) Expansion and replication of programs such as those described here.
2) Comprehensive crisis intervention services designed for children and adolescents and their families (not mixed with adults); including mobile teams who travel to the site of the crisis.
3) More non-hospital therapeutic residential alternatives for youths who are mentally ill and also dependent and unable to live at home.
4) More availability of short-term psychiatric hospital beds, including secure beds, to public sector patients, particularly adolescents.

5) Family support services such as respite care, baby-sitting, homemakers, parent training, recreation and even vacations; anything which helps that family cope more effectively and keep their child at home.

My final comment expresses both my frustration and hope at being a provider of, and an advocate for, children's mental health services. In 15 years of examining many policies, procedures, laws and regulations promulgated by City, State and Federal government, my assessment has been more often than not, "oops, they forgot the kids." I am pleased to note that in the Congress there is a Committee of Representatives who have made a commitment to children and adolescents, including those with mental health problems. Thank you for the opportunity to help you with your important work.

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To Reclaim a Legacy: Social Rehabilitation

Ruth Sefarbi, M.S.W.

ABSTRACT: The article describes the first year of the Social Rehabilitation Program for children and their families at the Philadelphia Child Guidance Clinic. A parallel is drawn with the beginning of family therapy and the ecological approach under Salvador Minuchin in 1965. It traces the difficulty in maintaining outreach community work because of funding problems and productivity requirements of the funding agency, and ends with the return to the community approach under the new program. The program is described primarily through case examples.

It is commonly held that 10 percent of the clients in the mental health system utilize 90 percent of the services. Since services often include extensive psychiatric hospitalization which is extremely costly, funding sources have been attempting to decrease institutionalization of the chronically and severely emotionally disturbed.

Unlike programs blindly involved in "de-institutionalization" which extrude individuals from institutions without sufficient planning and provision for their survival in the community, social rehabilitation programs have been designed which do provide support for the transition. One of the major goals of social rehabilitation programs is the integration into the community of the hospitalized client, or at least the extension of the periods that the client is able to stay out of the hospital. Social rehabilitation often consists of all-day programs where clients participate in activities geared to developing or increasing competence in areas ranging from personal hygiene and communication skills to vocational training and job hunting.

A Social Rehabilitation Program for Children

In July 1984, the Philadelphia Child Guidance Clinic (PCGC) was requested by the County to institute a social rehabilitation program which, to the best of our knowledge, was to be the first for children in the country. There is such a program in Motala, Sweden, begun in 1983 under the direction of Dr. Olof Ulwan. (Ulwan, Peterson, Jansson & Bratbaak, 1985, 1985a) During a visit here in August 1984, Dr. Ulwan shared most generously his experience with the program. Since he also acknowledged his debt to PCGC for his understanding of families, particularly disadvantaged, multi-problem families, an understanding which had contributed significantly to the development of his program, Dr. Ulwan's visit constituted the completion of a circle.

The new social rehabilitation program at PCGC restored to the Clinic a practice of providing broad and intensive services to children and their families in their homes and in the community as well as in the Clinic's facilities. This was a practice Dr. Ulwan and many others had learned from us, and which in large part had been lost because of changes in funding and State requirements. Restorations of this sort always follow some external stimulation or facilitation. In this case, the facilitator was Dr. Richard Surles, the new County Administrator of Mental Health and Mental Retardation. Dr. Surles is dedicated to preventing unnecessary hospitalization and to salvaging children's lives. His approach to those problems fit in with an earlier conceptualization of the Clinic's, described below, and his role in instituting the social rehabilitation program here represents another closing of a circle.

An Ecological Approach

Since the introduction of structural family therapy to the Clinic by Salvador Minuchin in 1965, PCGC had been committed to working with children not only within their families but within the context of their total environment. Therapists trained at the Clinic at that time understood the importance of seeing clients in their homes, of becoming familiar with their neighborhoods; of working closely with the schools; of acting as "Ombudsman" in relation to the many agencies our disadvantaged clients were entangled with. Such an ecological approach was one of the reasons for the tremendous excitement that pervaded the Clinic in those days.

The roots of the structural-ecological framework may be found in the work of Minuchin and his colleagues at the Wiltwyck School for Boys, a

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The therapists who worked on this project are Pat Goodman, Sara Thomas, Rick Nelson, Roosevelt Spruill and Muriel Shapp.

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residential facility for delinquents, prior to Minuchin's assuming the directorship of PCGC. *Families of the Slums* (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967) compared a group of disorganized, disadvantaged families containing more than one delinquent child with a group of families who had many of the same characteristics but no delinquent children. The study provided a rich and complex body of information which laid the ground work for the structural family model. Minuchin and Montalvo (1967) described techniques for working with disorganized low socioeconomic families by shifting the composition of subgroups within families as a way of helping them to differentiate their global responses and change communication patterns. Auerswald (1968), formerly director of Wiltwyck, compared the interdisciplinary versus the ecological approach, and emphasized the importance of the interfaces between the conceptual frameworks of different disciplines. He contended that they were largely ignored, and that, as a result, "the interfaces between the various arenas of systematic life operation (e.g. biological, psychological, social or individual, family, community) represented by different disciplines are also ignored" (p. 204). At PCGC, Minuchin and his staff continued to develop an "eco-structural"[1] philosophy. Minuchin advocated "change-producing interventions of such a nature that both child and social structure become targets for concurrent change." (Minuchin & Minuchin, 1976, p. 133)

An illustration of such a change-producing innovation was the family-school interview (Aponte, 1976), held at the school as a first session. The family-school interview was a significant development of that era and was in keeping with Minuchin's (1964) recognition that a child's behavior might sometimes be caused by "outside" factors such as his school—teacher, curriculum, peers—rather than by intrapsychic factors. The format was used primarily when children who had no apparent problems at home, were referred for problems, sometimes of a very serious nature, at school. Holding the interview at school allowed for the involvement of a maximum number of school personnel: principal, counselor, and teachers. It was designed to find solutions rather than to dig for causes of trouble. Making it the initial contact enabled the school to maintain a primary sense of responsibility with the family, from the beginning, to find a solution.

In a more encompassing manner, however, the following case best describes the way in which the eco-structural approach actually worked. The case, described by Aponte (1974), concerns a single-parent mother, depressed and often bed-ridden with severe psychogenic stomach pains. She was

> "living in the twilight of heavy doses of prescribed drugs," and was dependent on her four children for physical and emotional sustenance. The mother brought her ten-year-old son in to PCGC as the identified patient because he was having problems in school. Aponte notes that the two therapists assigned to the case could have talked with the mother about many things. What they *did*, after assessing the situation, was to go home with her, and have the family plan a meal under the mother's direction. The therapists went shopping with the family, joined the mother in preparing the meal as her assistants, and modelled giving the children age-appropriate duties to perform for their mother. In sum, the therapists helped the mother assume an executive role in relation to the meal preparation that evening and actively supported her taking charge of the household thereafter. Such support involved intervention at many levels. At times the therapists saw the family together, at times separately, at times with the entire family, on occasion with one member alone, at other times with school personnel, and in some instances with other members of the community. The mother was depression free and able to give up pain-killers after a few weeks. Beyond the symptom removal, the therapists helped the mother to become a competent adult who dated and involved herself in community activities, as well as to become a competent mother. With the help of the therapists, the family learned new patterns of communication and problem solving, and the mother could allow her children to function as children.

Losing the Legacy

By the late 1970s, funding restrictions and productivity requirements made it difficult to continue in that direction. Stringent limits were placed on the type of situation that would justify making a visit to a client's home or school. Only "face-to-face" contacts with clients counted as productivity. Conferences with school counselors, vocational rehabilitation counselors, probation officers, for example, that did not include the client, had to be eliminated or severely curtailed. The number of hours one could spend with a client at all was limited to seven a month, adequate for many families but not always for the most needy.

When the restrictions on home visits were later removed, clinicians remained confused as to whether home visits were really legitimate and under what circumstances. Since travel time did not come within the productivity quota, therapists often could not afford the time to go to a client's home anyway. The ecological tradition continued at PCGC. It was practiced to varying degrees however by only the most dedicated therapists and those well-organized enough to juggle the demands, often bewildering, of productivity quotas and record keeping—all the while attempting to work with multi-problem, high-risk families among the extreme poor.

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[1] A phrase utilized by Harry Aponte, Director of PCGC from 1975 to 1979

The Dilemma

The new social rehab program, with its goal of preventing institutionalization, sanctioned unlimited outreach. It was an exciting concept, but the abrupt change of direction and the lack of guidelines for meeting the expectations of the program produced acute anxiety among the staff. It seemed we were being asked to carry out a new type of program with no precedent for how to do it. The day treatment model was not appropriate; our clients were virtually all school age and attending local schools. Anxiety was reflected in staff meetings by the continually recurring question, "Just what *is* social rehab?" and there was more than a little frustration about not getting the answer. We thought we knew what it was not. It was not therapy. We were intimidated by our belief that recordings of interviews were to reflect that we were not doing therapy but "rehabilitating" clients by connecting them with the appropriate resources in the community. Faced with ambiguous and bureaucratic semantics, anxiety threatened to give way to total paralysis. But the cases were coming and we had to respond to them.

The Task

Gradually we recognized that there was no answer and that we had to take responsibility for developing our own form of social rehabilitation. We began to reconnect with our past and reintegrate the practices described by Aponte (1974), which presaged the social rehabilitation program.

Dr. Ulwan's presentation (1984) early in the life of our program was extremely helpful. There was a difference in age range: his program targeted youngsters aged 16 to 24; our upper age limit for the children was 19 with no lower age limit. In both programs however families were expected to be part of the treatment. The families in Ulwan's program, like the families in ours, were the most disorganized, the most resistant to treatment yet the ones most in need of treatment. The two most experienced and skilled family therapists in Ulwan's group worked with the families intensively in their homes for six months. Following that intensive treatment period, the families were able to work on an outpatient basis with one of the other therapists in the program. There were a number of important components to the program; e.g., they began each case with a conference which included the family and all the agencies involved to avoid sabotage by any one element, and there were regularly scheduled group meetings for the parents of the youngsters.

It is not the intention of this paper, nor would it be possible, to describe their program in detail. It should be noted however that while Ulwan's group had several psychiatric beds on reserve, they had not had to hospitalize a youngster for even one day since starting the program.[1] From our viewpoint, it was significant that Ulwan's program accomplished its results by emphasizing both clinical and community work. This was a model that was syntonic with our own approach and goals.

At the same time, we recognized that we had to expand our knowledge of community resources, even though we already had community-oriented backgrounds. In addition to years of experience at the Clinic, the clinicians in the program had received their professional training in schools of social work, or had participated in a two-year, full-time training program at PCGC in family therapy. Those in the latter group were individuals who were indigenous to the community, and had been selected on the basis of their personal qualifications and their life experience. For both groups the training, to an infinitely greater degree than the training provided for other disciplines, emphasized the role of community resources in the lives of clients. Nevertheless the specialized work in the social rehab program, we found, required much more in relation to community involvement and networking than we had previously needed to give. We unreservedly plunged in to exploring not only the traditional resources but to tracking down individuals and grass roots organizations that might provide furniture, clothing and other necessities for our clients.

Another major difference was in the intensity of the service provided. Clinicians can, and do, see clients several times a week, every day if necessary to support them during a period of transition: to help them cope with a new environment, to motivate them to attend a new school or vocational training program, or to monitor a potentially explosive situation.

While we do not, in the program, ignore individual problems, we take seriously the "social" in social rehabilitation. Many of the sessions take place in the clients' homes and in other locations in the community—the school, the court, the local recreation center, the Department of Public Assistance Office, the employment office—and they include staff from other agencies and institutions as well as members of the client's extended family, all of whom comprise the client's network. When possible, we refer clients to one of our adolescent groups and their mothers to the mothers' group. We are sometimes able to supply families with tickets to various museums and entertainment events in the city, or arrange for a group to take a trip together. All of these activities fill an important socializing function for the client and other family members.

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[1] As of September 1985, Ulwan's program had seen 64 youngsters and their families, and continued to be successful in avoiding hospitalizations. (Personal communication, 9/13/85)

The Program Population

Our client population is characterized by children and adolescents who are often suicidal, compulsive runaways, chronic school adjustment problems, or uncontrollably aggressive. They come from families where the parents themselves often have had extensive psychiatric outpatient and inpatient histories. Many of them have backgrounds of alcoholism and drug abuse, and have been neglectful and abusing parents. As already indicated, this population is characterized as well by severe economic deprivation, which plays a major role in the problems of the families and the children, and which requires connecting them to basic resources in the community.

In our hierarchy of clients, the children being discharged from Eastern State School and Hospital are our first priority since they require the most intensive work to reintegrate them into the community. Next are the children in our inpatient unit at PCGC who may be diverted from Eastern State by referral to our social rehab program. Finally, and the largest group in the program, are the children who typically are brought to the Clinic only in times of crisis but whose families don't follow through with treatment after the crisis is resolved. They disappear until the next crisis at which time they again require an emergency response, often including hospitalization for the child or for the entire family in one of our inpatient apartments. The pattern may be repeated endlessly with no apparent way to prevent another crisis and another hospitalization. That is the situation in which the social rehab therapist intervenes, to try and break the cycle by reaching out, by going to the family's home and bringing to the family intensive therapy and other services.

Case Examples

Examples of some of the cases in the program best convey the kinds of problems we work with and the ways we have developed to handle them.

Case 1

One young girl I'll call Claire who is now 14 came from Haiti with her family several years ago. The family is here illegally. They speak little English, and they struggle just to survive. Claire was hospitalized in our inpatient unit four times in 1983, anorexic on one admission, catatonic on another. In 1984 she was hospitalized again, for the fifth time, in a manic psychotic condition, and upon discharge, went to Eastern State. Since she went on a voluntary basis, she was able to sign herself out, which she did after several weeks.

At that point, Claire was admitted to our then newly formed social rehab program. Her therapist, Pat, worked with her and her family intensively, making numerous home visits. She worked to develop a boundary between the father and Claire (there had been indications of incest). She also involved Claire in an adolescent group in the Clinic, and consulted extensively with the school counselor to find a school that would meet her special education needs. Claire was eventually admitted to the Delta School which is a good school for special needs children, and she is adjusting well there. In sum as Braulio Montalvo, consultant to the program, picturesquely put it, "the therapist really stitched the girl into a whole new social fabric."

Case 2

Kate, who is 16 years old, had been abandoned by her mother who was herself mentally ill, and had spent her entire life in foster homes and institutions. After getting into a fight at one of her residential placements, she was sent to Eastern State because of her supposedly violent, uncontrollable anger. While she was at Eastern State, her mother died. At the funeral her relatives got together and decided to do something for Kate. One of her brothers offered to have her live with him and his girlfriend, and Kate was released to them.

After a time, Kate ran into serious problems with her brother's girlfriend. One problem had to do with the economic situation and the attempts of the brother and his girlfriend to eke out their food supply. Kate was not allowed to go to the refrigerator and she was often literally hungry.

Fortunately, Kate had also been referred to us when she was discharged from Eastern State. Her therapist worked with Kate to reacquaint her with her relatives and help her to cope with them. She eventually got Kate connected with a sister who had more resources than the brother, and was able to provide a supportive environment for her. After a lifetime of institutionalization, Kate is going to school and developing a network of friends as well as reconnecting with her family and with the community.

Case 3

One of the social rehab therapists inherited a boy, Stephen, who at the age of 12 had already been an inpatient twice at PCGC and was at Eastern State for the second time. At age two, he had been sexually abused by his father and his parents' marriage broke up as a result. The mother resented Stephen for that. In an irrational way, she held the boy responsible for the break-up of the marriage and that created a pathological tie between them. The mother's behavior toward Stephen was triggered by guilt, and his toward her by anger. He could never confront his mother directly with any negative feelings but instead acted them out. Stephen was never held accountable for his behavior because his mother protected him. She covered up for him when he got into trouble with the law. Stephen ran away from Eastern State right before the court hearing at which he was scheduled to be discharged to his mother. When he was found, he was sent home anyway. He had been a problem to them at Eastern State, they didn't know what to do with or for him.

The social rehab therapist worked with Stephen and his family (his mother and brother) on restructuring their relationships. The mother was able to change her perception about Stephen's responsibility for ending the marriage. Mother and son embarked on a process of psychological separation.

When the boy became homicidal at one point and was caught with a gun, he was, after a brief hospitalization at PCGC, sentenced to the Youth Development Center at Bensalem for six months. Instead of protecting him as she had in the past, his mother cooperated in having him placed there. For the first time, Stephen was held accountable and was expected to deal with his behavior in a structured setting. Stephen felt better about being at Bensalem than about being considered crazy. Especially important, Stephen was brought to PCGC from Bensalem for regular family sessions. Work continued with the family during the post-incarceration period as well.

Case 4

A final example, which could serve as a model for social rehab cases, is that of Melinda, one of five children, who was referred to PCGC several times prior to the inception of the social rehabilitation program. She was 13 when she was first referred because of depression. Melinda was retarded and had a speech problem in that she was unable to express herself coherently. At one point, she became disoriented and started wandering around the city, a situation which necessitated a period of hospitalization at PCGC.

The case bridged the period during which the social rehabilitation program was formed. The therapist was assigned to the new program and he transferred Melinda to it as well. Following Ulwan's model (1984) in which the therapist works intensively with the family for a time-limited period, he explained to the family the reason for putting them into the social rehab program: he would be able to give them as much time as they needed for a specific period.

The therapist marshalled all the support he could find to break the cycle of repeated crises and escalating problems. He brought in an older sister who had a poor relationship with her mother and had left home. He was able to re-involve her to support her mother and Melinda. Melinda's speech problem dated back to early childhood when the family, aware that there was something wrong with the child, would anticipate her needs so that she didn't have to speak. When she got older and the family expected her to talk, her speech was incoherent. The family would laugh at her or otherwise put her down, and the girl, filled with suppressed anger, withdrew.

The mother had refused to accept that Melinda was retarded. Now the mother was helped to accept it. The therapist modelled for the mother and the older sister how to help Melinda speak, how to track her conversation and help her to express herself. The mother had complained about not understanding what young girls needed. The older sister helped both the mother and Melinda to learn how Melinda could act in an age appropriate way. The mother had only known how to supervise the girl. Now she learned to nurture her as well. She did volunteer work at Melinda's school in order to become more involved with her.

To provide more support for the mother, he referred her to the mothers' group. The group encouraged her to seek a paid job, which she eventually obtained. They also encouraged her to take greater control over her children, and specifically to get her 20-year old son out of the house. In turn, the son got himself a job and a government gift house which he has been rehabilitating himself. Another son, released from jail after 10 years, has been successfully integrated into the family. The relationship between the mother and her older daughter has continued to improve.

Our client, now almost 15, has been adjusting well to special class in high school. She has achieved considerable success in sports, has in fact won three first place trophies in Special Olympics for her performance in track. She is acquiring a network of friends, and can speak more normally. She has learned to express herself, and to communicate with her family.

With so much improvement, the case was transferred to case management status, which involves periodic visits on a follow-up basis with a case manager. Since the family had been primed from the beginning to view social rehab as extremely intense but time-limited, they could accept the transfer as an achievement rather than as a rejection or as a painful separation. (The advance preparation also helped the therapist to separate from *them*!)

The emphasis for this family in case management is on competence. The mother still has problems but she handles them. In the sessions which are held every few weeks with our case manager the mother talks about the way she handles her problems. The mother's competence is supported and expanded. Currently, the mother is doing extremely well both in her job as a full-time school aide, and in her social life which is complete with church activities and a gentleman friend.

Program Evaluation

The program includes an ongoing evaluation component which evaluates both the program itself and the treatment outcomes of the families. The program evaluation looks at whether we are admitting the type of families we outlined in our hierarchy of priorities, and whether we are providing the kinds of services (intensive, community-based) we intended. For the treatment outcomes, we look, among other things, at the number of client hospitalizations after entering the program, the type of hospitalization and the reason for it.

According to our evaluation data at the end of the first year, the seven clinicians in the program served 96 clients and their families. Fifteen of the clients had been at Eastern State; thirty-one had been hospitalized at PCGC, many of them more than once, and eleven had been hospitalized at other hospitals such as Philadelphia Psychiatric Hospital and Eaglesville.

In the first year, none of our clients had to be admitted or readmitted to Eastern State. Only eight have had to be hospitalized since entering the program, six of them at PCGC. Significantly, all were planned admissions with definite plans for follow-up after discharge, very different from the previous cycle of emergency hospitalization our clients had been involved in.

Team Spirit and Support

One explanation for the effectiveness of the program may be found in the unique team spirit of the staff. The group meets together for two hours every week to share information about hard-to-find resources. They also share experiences, particularly in relation to difficult cases. (One of our therapists had her life threatened by the boyfriend of a client—staff members are very supportive of one another at times like that.) Out of the common goals of the program, a strong and cohesive group has developed. As an example, when we recently trained a group of inpatient staff to work with us, the training was primarily the responsibility of one therapist. Yet every therapist in the program voluntarily participated in the training, even though it took place on two weekends.

Still in the formative stage is the development of host homes as an alternative to institutionalization for those children who have no families or who are unable to live with them. Our staff will train the host home parents. A therapist will work with the child and with the natural family, if available, to enable them to maintain contact with one another, and to facilitate the child's eventual return to the natural home, when that is possible.

Plans for the host homes are being made with full and necessary acknowledgment that some families of origin are too incapacitated to immediately receive back home a youngster who had been institutionalized.

Conclusion

The impressive lesson of our experience thus far is that many families can receive their children from institutions or prevent them from going in the first place if they have the necessary support. Our clinicians are extremely skilled and sensitive, but their results can be duplicated by clinicians in other programs given the willingness and the jurisdiction to work in the same way.

What is required to provide such jurisdiction? In what context can this type of program best flourish? Therapists may find it difficult to resist the pressure for hospitalization; the demands on them are much greater when working with a family in crisis outside the hospital. In order to support the families, they in turn need support from their parent organizations to sustain them through those crises. Such support is often difficult for organizations to give because funding allocations are so heavily oriented toward the medical as opposed to the psychosocial aspects of rehabilitation.

Organizations fail to recognize that the type of program described above not only results in the salvaging of human lives, but is economically desirable in its effective use of available funds. It is a program in which the inherent competence of the individual is valued, in which priority is given to the normalization of the client with a watchful eye toward unnecessary institutionalization. In short, it is a program in which hospitalization is viewed and utilized only as a last resort.

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Chairman MILLER. Thank you.
Mr. L'Homme.

STATEMENT OF BERTRAND P. L'HOMME, EXECUTIVE DIRECTOR, CITY LIGHTS, WASHINGTON, DC

Mr. L'HOMME. Mr. Miller, members of the committee, thank you for inviting me here today to tell you about City Lights.

In August of 1981, a District of Columbia Superior Court judge approved a consent decree settling the landmark case of *Bobby D.* v. *Barry*. The class action lawsuit filed in 1977 challenged the failure of the District of Columbia's Department of Human Services to provide noninstitutional care for 600 children who had been adjudicated neglect and placed in its custody.

In June 1987, 10 years after the *Bobby D.* suit was filed by the Children's Defense Fund, a District of Columbia Superior Court judge found that a residential treatment center in Texas that charges $120,000 a year to treat District youth was grossly incompetent and literally life threatening. The charge was made after a 17-year-old District youth was injected with an antipsychotic drug when he refused to put on his pajamas and then received daily dosages of other powerful drugs despite no evidence of psychosis. It would seem little has changed.

The Children's Defense Fund surveyed the *Bobby D.* case and found the majority of underserved and misserved handicapped wards were emotionally disturbed adolescents. Under the auspices of the Children's Defense Fund, City Lights was founded by Judith Tolmach Silber in September of 1982.

When City Lights opened its doors to its first students on the corner of New York Avenue and North Capitol Street, literally in the shadow of the Nation's Capitol, we intended to serve a group of the most disturbed and delinquent adolescents in the District of Columbia. The mission of City Lights is to provide a community-based day treatment program for adolescents as a last resort before institutionalization and to receive adolescents back into the community subsequent to institutionalization.

City Lights claims no new insights into the causes of emotional disturbance and juvenile delinquency. We have developed no new technique that will cure the traumas of physical and spiritual neglect. We have not found a way to remove the scars of physical, psychological, and sexual abuse. But we have developed and implemented a determined, structured, and consistent system of care that allows students to grow, mature, and become independent.

When we talk about childhood trauma, we know one trauma can often hamper normal childhood development. The students at City Lights have suffered multiple traumas. For example, two years ago a student came into my office and asked to speak to me. He related a gruesome story that involved an adult male who had been involved in his care previous to City Lights. He told me about several hundred black adolescent boys and about several thousand nude pictures of those boys that were taken by this adult over a 15-year period. Sitting with him in a waiting room at the police station, this young man told me that this was the third time he had been to the police station for situations related to sexual abuse. A few months later, I asked this young man why he smoked Love Boat—PCP—and he responded, "Mr. L'Homme, it's the only time I don't hurt."

If there is a typical student at City Lights, he is 16 years old, black, male, a ward of the District of Columbia, emotionally disturbed, delinquent in reading and computing math below the third grade level. All the students at City Lights are residents of the District of Columbia, where 44 percent of all students who entered ninth grade in 1986 will not graduate and 10,000 children are out of school every day.

In the District, there are 16,000 heroin users, 60,000 polydrug users—PCP, cocaine, and marijuana. Every year, 4,000 juveniles are apprehended for offenses ranging from very minor, noncriminal behavior to the most serious felony crimes. While 48 percent of white adolescents are working, only 27 percent of black adolescents are working.

Students at City Lights fill a very special category, the structurally unemployed. Even if there are jobs, City Lights students will not get them. Immediately, questions arise. Is it worth our effort? Is it worth the investment of millions of dollars? And, is it worth the allocation of already overwhelmed resources? If the answer is yes, then how will we intervene in a vicious cycle of rejection and failure?

In 1987, the answer all too often is to build bigger and more secure detention facilities. City Lights set up a comprehensive array of educational, clinical, and vocational services based on the psycho-educational model which assumes that cognitive and affective processes are in continuous interaction. The staff believes that the milieu itself is therapeutic and that everything in a child's day can be used as a therapeutic intervention.

But the school that City Lights set up in 1982 was no longer enough in 1984. There was no school to assist multi-problemed older adolescents and young adults make the difficult transition from school to work and from dependence to independence.

In 1984, under a grant from the Department of Education, City Lights set up the Workplace, a school and work transition program for students between the ages of 16 and 26 years old. City Lights assembled a consortium of agencies that originally allowed us to offer this crucial service for $10 a day; a service that included a full remedial education program, complete clinical services, job placement and monitoring and follow-up for $10 per day per student; a service that took City Lights over two years to sell to the District of Columbia and today, at the end of three years, is only 50 percent enrolled.

We continually ask ourselves what makes the difference in the lives of the students entrusted to our care. Two years ago, under a grant from the National Institute of Handicapped Research, we found and interviewed 50 of our first 68 graduates. At the time of follow-up, we determined to what degree students were working and living independently.

The second question asked whether students were placed in a more or less restrictive environment at the time of disposition and follow-up. Quite simply, those students who attained a higher level of independence and were in a less restrictive environment at the time of follow-up attended City Lights longer; had grown up in one long-term foster home; had regular and SYEP work experience; and were likely to be depressed rather than character disordered, reading at least at the fifth grade level, and computing math at least at the sixth grade level.

From preliminary analysis of our data, we identified several predictive factors that we had no control over: diagnosis, foster home placement, et cetera, and several factors that City Lights could influence: work experience, attendance, math, reading. We understood that influence on these factors can only occur within the context of our therapeutic community with a comprehensive and determined strategy of education, therapy, vocational education, and job placement.

City Lights has identified some of the problems, developed solutions, implemented programs, and has proven our effectiveness, yet the City Lights programs are in continuous danger of closing. It is a fact of life that if City Lights is not able to secure additional contracting grants in the next two months, City Lights will close before school opens next September.

City Lights, like all nonprofit organizations who have proposed solutions to complex problems, is dependent on contracts from public agencies and private foundations. City Lights is confident that, with fair contracting and granting procedures, we will continue to provide high quality services to the students of the District of Columbia.

However, in light of recent events, City Lights, along with several other respected nonprofit agencies, suggests several proposals, the first to include a request that District agencies secure the services of third party specialists to sit on the contract review boards. Second, we propose that each nonprofit agency be reviewed and evaluated by a committee of its peers from the public and private sector. These steps, we feel, will go a long way toward restoring confidence and ensuring fair contracting procedures.

Beyond theory and technique, City Lights communicates and models a set of values that allows students to become independent adults in the community. Briefly, we value education, and we believe that learning to read and compute math is the most powerful tool we possess for developing self-esteem and self-worth in our students.

We believe that problems are solved by talking, listening, and then acting. We value students and staff who take risks, and we appreciate and accept differences of race, sex, and age. We expect high standards of achievement from staff and students, and we believe only authentic relationships are therapeutic. We believe students trust adults who can say no, and we believe we must be able to collaborate with the student, with each other, parents, guardians, public agencies, and the community. And, finally, we believe that kids can get better and multi-problem, high-risk youths can be helped to help themselves.

Thank you.

[Prepared statement of Bertrand Paul L'Homme follows:]

PREPARED STATEMENT OF BERTRAND PAUL L'HOMME, EXECUTIVE DIRECTOR, CITY LIGHTS, WASHINGTON, DC

In August 1981, a District of Columbia Superior Court Judge approved a Consent Decree settling the landmark case of Bobby d. v Barry. The class action lawsuit filed in 1977, challenged the failure of the District of Columbia's Department of Human Services to provide non-institutional care for the 600 children who had been adjudicated neglect and placed in its custody.

In June 1987, ten years after the Bobby D. suit was filed by the Childrens Defense Fund, a District of Columbia Superior Court judge found that a residential treatment center in Texas that charges $120,000 a year to treat District youth was 'grossly incompetant, and literally life threatening.' The charge was made after a 17 year old District youth was injected with an antipsychotic drug when he refused to put on his pajamas and then received daily dosages of other powerful drugs despite no evidence of psychosis.

The Childrens Defense Fund surveyed the Bobby D. class and found the majority of underserved and miserved handicapped wards were emotionally disturbed adolescents. Under the auspices of the Childrens Defense Fund, City Lights was founded by Judith Tolmach Silber in September 1982.

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When we talk about childhood trauma, we know one trauma can often hamper normal childhood development. The students at City Lights have suffered multiple traumas. For example, two years ago a student came into my office and asked to speak to me. He related a gruesome story that involved an adult male who had been involved in his care previous to City Lights. He told me about several hundred black adolescent boys and about several thousand nude pictures of those boys that were taken by this adult over a fifteen year period. Sitting with him in a waiting room at the police station, this young man told me that this was the third time he had been to the police station for situations related to sexual abuse. A few months later I asked this young man why he smoked 'love boat' (PCP) and he responded, "Mr. L'Homme it's the only time I don't hurt."

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All the students at City Lights are residents of the District of Columbia where 44% of all the students who entered 9th grade in 1986 will not graduate and 10,000 children are out of school every day. In the District there are 16,000 heroin users and 60,000 poly drug users (PCP, cocaine, marijuana). Every year 4,000 juveniles are apprehended for offenses ranging from very-minor non-criminal behavior to the most serious felony crimes. While 48% of white adolescents are working, only 27% of black adolescents are working. Students at City Lights fill a special category, the structurally unemployed, even if there are jobs City Lights students will not get them.

Immediately questions arise -- is it worth our effort, is it worth the investment of millions of dollars, and is it worth the allocation of already overwhelmed resources? If the answer is yes, then how will we intervene in a vicious cycle of rejection and failure. In 1987, the answer all too often is to build bigger and more secure detention facilities.

City Lights set up a comprehensive array of educational, clinical, and vocational services based on the psychoeducational model which assumes that cognitive and affective processes are in continuous interaction. And the staff believes that the milieu itself is therapeutic and that everything in the child's day can be used as a therapeutic intervention.

But the school that City Lights set up in 1982 was no longer enough in 1984. There was no school to assist multi-problemed older adolescents and young adults make the difficult transition from school to work and dependence to independence. In 1984, under a grant from the Department of Education (OSERS) City Lights set up The Workplace, a school and work tranisition program for students between the ages of sixteen and twenty-six years old. City Lights assembled a consortium of agencies that originally allowed us to offer this crucial service for $10.00 a day. A service that included a full remedial education program, complete clinical services, job placement and monitoring, and follow-up for $10.00/day/student. A service that took City Lights over two years to sell to the District of Columbia and today at the end of three years it is only fifty percent enrolled.

We continually ask ourselves, what makes a difference in the lives of the students entrusted to our care? Two years ago under a grant from the National Institute of Handicapped Research we found and interviewed fifty of our first sixty-eight graduates. At the time of follow-up we determined to what degree students were working and living independently. The second question asked whether students were placed in a more or less restrictive environment at the time of dispositon and follow-up.

Quite simply those students who attained a higher level of independence and were in a less restrictive environment at the time of follow-up attended City Lights longer, had grown up in one long term foster home, had regular and SYEP work experience, were likely to be depressed rather than character disordered, reading at least at the 5th grade level and computed math at least at the 6th grade level. From the preliminary analysis of our data we identified several predictive factors that we had no control over (diagnosis, foster home placement,etc.) and several factors that City Lights could influence (work experience, attendance, math and reading scores). We understand that influence on these factors can only occur within the context of our therapeutic community with a comprehensive and determined strategy of education, therapy, vocational education, and job placement.

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Sept [illegible]

PHOTOS BY MOLLY ROBERTS FOR THE WASHINGTON POST

nell Robinson attends school about half time.

On the Road to the Street

Truants Feed D.C.'s 32% High School Dropout Rate

By Edward D. Sargent
Washington Post Staff Writer

Since September, Sousa Junior High School has been in session about 144 days, and Donnell Robinson has been marked absent more than 80 of them, according to his principal.

The seventh grader, who had a C-plus average earlier this year and says he likes learning and hopes to be a policeman, spent those days "hanging out" or playing hide-and-seek with friends.

At 14, Donnell is showing patterns of truancy that, according to D.C. school officials, almost inevitably turn students into dropout statistics by age 16.

About 10,000 D.C. students stay out of school each day, putting the city's absentee rate at 12 percent, among the highest in the nation, according to Marilyn Brown, assistant superintendent for student services.

About 32 percent of the city's high school students drop out each year, resulting in considerable numbers of youths in the District who are undereducated and unskilled.

Administrators said that more than 20 percent of the truant youths and those who drop out each year have borderline learning disabilities, like Donnell, who is enrolled in a special education program at Sousa.

Some truants are casual class-cutters, who may miss fewer than a half-dozen school days each year to go shopping or take advantage of a nice day. But many, like Donnell, are chronic truants who skip school because they feel alienated.

He said of his many absences: "I don't like my teachers or the principal . . . . I want to get transferred to another school."

See TRUANT, D5, Col. 1

Donnell, 14, spends another day as a truant.

USA TODAY

2/21/86

Dropout rates

Here's the percentage of 9th grade students that don't make it through graduation in each state.

	1982	1984	Rank*
Ala.	36.6	37.9	3
Alaska	35.7	25.3	27 T
Ariz.	36.6	35.4	11 T
Ark.	26.6	24.8	30T
Calif.	39.9	36.8	8
Colo.	29.1	24.6	31
Conn.	29.4	20.9	41
Del.	25.3	28.9	18
D.C.	43.1	44.8	1
Fla.	39.8	37.8	5 T
Ga.	35.0	36.9	7
Hawaii	25.1	26.8	22
Idaho	25.6	24.2	32
Ill.	23.9	25.5	25
Ind.	28.3	23.0	35
Iowa	15.9	14.0	48
Kan.	19.3	18.3	43
Ky.	34.1	31.8	13
La.	38.5	43.3	2
Maine	27.9	22.8	37 T
Md.	25.2	22.2	39
Mass.	23.6	25.7	24
Mich.	28.4	27.8	19
Minn.	11.8	10.7	51
Miss.	38.7	37.6	6
Mo.	25.8	23.8	34
Mont.	21.3	17.9	44
Neb.	18.1	13.7	50T
Nev.	35.2	33.5	12
N.H.	23.0	24.8	30 T
N.J.	23.5	22.3	38
N.M.	30.6	29.0	17
N.Y.	36.6	37.8	5 T
N.C.	32.9	30.7	15
N.D.	16.1	13.7	50T
Ohio	22.5	20.0	42
Okla.	29.2	26.9	21 T
Ore.	27.6	26.1	23
Pa.	24.0	22.8	37 T
R.I.	27.3	31.3	14
S.C.	37.4	35.5	9
S.D.	17.3	14.5	47
Tenn.	32.2	29.5	16
Texas	36.4	35.4	11 T
Utah	25.0	21.3	40
Vt.	20.4	16.9	45
Va.	26.2	25.3	27 T
Wash.	23.9	24.9	28
W.Va.	33.7	26.9	21 T
Wis.	16.9	15.5	46
Wyo.	27.6	24.0	33
Ave.	30.3	29.1	—

Source: U.S. Department of Education

*T means a tied ranking

Jan 2, 1987

D.C. Judge Blasts Treatment Center

Texas Youth Facility Called Incompetent, Abusive, Life-Threatening

By Elsa Walsh
Washington Post Staff Writer

A D.C. Superior Court judge has found that a residential treatment center in Texas that charges the District $120,000 a year for each District youth treated there is "grossly incompetent, abusive and literally life-threatening."

Judge Curtis von Kann made his findings about the Brown School in Austin after hearing testimony that a 17-year-old District youth placed there was injected with an antipsychotic drug when he refused to put on his pajamas and then received daily dosages of other powerful drugs despite no evidence of psychosis.

In a 78-page ruling, the judge said it was clear to him that authorities at Brown School were not using the drugs to treat the 17-year-old "but rather to control him and to make him compliant."

The judge ordered District officials to find a different program for the youth and strongly suggested that the city review the placement of other District youths who may be there.

It was unclear yesterday how many District youths are at Brown, a psychiatric and educational treatment center, but the judge said the 17-year-old indicated he knew of at least one other District resident at the facility, which was recently renamed the Health Care Rehabilitation center.

Nearly 300 District youths are placed in residential treatment programs outside the city for special therapeutic and educational programs that District officials say are unavailable in the city. About half of them are placed there by court order.

"The court has no reason to believe that the serious mistreatment displayed by Brown is limited to this one patient," the judge wrote in an opinion issued last week.

The residential placement program, administered by the Department of Human Services, has previously been criticized by youth advocates who complain that District officials rarely visit or monitor out-of-state programs. Such a lack of attention, juvenile defense lawyers said yesterday, inevitably leads to cases such as the one before von Kann.

"Most attorneys you talk to who have a child in a residential placement will tell you a horror story about what goes on there," said Diane Shust, head of the juvenile division for the Public Defender Service. "The District spends millions of dollars on this program but nobody really does any monitoring."

D.C. officials responsible for the program were unavailable for comment but a "memorandum of understanding" signed by Mayor Marion Barry and other city officials in December 1985 announced the formation of a monitoring committee to supervise the residential placements.

Brown officials could not be reached for comment yesterday, but defended their treatment of the 17-year-old during a court hearing on his placement.

The youth arrived at the Brown School last October after he pleaded guilty to simple assault in a juvenile case and the Residential Review Committee concluded he needed long-term treatment for emotional and behavioral problems.

The judge said that shortly after the teen-ager arrived at the school he began complaining about his placement in a cottage with children who had serious head and other injuries and said he wanted to go home. When he made threatening comments to other residents on the fourth day, he was escorted to his room and told to put on his pajamas.

When he refused and then resisted staff members' efforts to undress him, the judge said, seven staff members physically restrained the youth in a straitjacket and injected him with Haldol, a drug with painful side effects used most often with psychotic patients or in a emergency to calm violent behavior.

"They just blasted him," one doctor told the judge during the hearing.

Three weeks later the youth was transferred to another unit and a psychiatriast who had no previous contact with him prescribed large daily dosages of Mellaril and lithium, drugs similar to Haldol in use and side effects.

The judge also sharply criticized an additional prescription by the psychiatrist for Mellaril every hour "as needed."

Had the 17-year-old "actually been given 100 milligrams of Mellaril every hour it would have killed him," the judge wrote.

The judge said the youth was allowed to stop taking the Mellaril 15 days later when he developed "the shakes." The youth, who is currently in a group home in the District, left Brown around Christmas after a request for a hearing from his lawyer, Joseph Tulman.

SCHOOL PERFORMANCES, RESOURCES

		SAT Scores	Rank*	% Tested	% Grads**	Rank	Avg. Salary	Rank
District	1982	821	21	53.2	52.8	51	$24.265	3
	1986	852	19	53.5	54.8	50	33.990	2
Maryland	1982	889	9	50.3	74.8	19	21,120	10
	1986	911	6	53.8	77.7	12	27,186	10
Virginia	1982	888	11	51.0	73.8	22	17,008	34
	1986	908	8	58.9	73.7	27	23,382	26
U.S.	1982	893			69.7		19.274	
	1986	906			70.6		25.313	

*Rank among 21 states and the District.

**Percent of ninth graders who graduate fom high school four years later; adjusted for migration and unclassified handicapped students; figures are for 1985.

NOTE: SAT scores include public and private school students. Other data for public schools only.

SOURCE: U.S. Department of Education.

Student Test Scores Hold Steady, Dropout Rate Rises, Bennett Says

District Shows Improvement in Nationwide Education Rankings

By Lawrence Feinberg
Washington Post Staff Writer

High school students' test scores leveled off last year and dropout rates inched up slightly after four years of improvement, U.S. Education Secretary William J. Bennett reported yesterday.

"We have basically held steady," Bennett declared at a news conference here as he released the department's annual state-by-state wall chart of education statistics. "We are holding the ground we have gained [since 1982] . . . . For future years, more effort is needed."

In both Maryland and the District, which was included among the state reports, the scores of college-bound high school seniors continued to rise, while in Virginia scores were unchanged. The dropout rate increased slightly in all three areas after decreasing for several years.

Meanwhile, spending per pupil and average salaries of teachers continued to rise substantially both locally and across the country.

At $33,990, the average salary of D.C. public school teachers last year was the second highest in the country after Alaska. The District's school spending per student, based on average daily attendance, was $4,571, ranking fifth in the nation in 1984-85, the most recent year for which comparative data was

scores were used to make comparisons. Its dropout rate of 45.2 percent was the second worst in the nation, just ahead of Louisiana, though D.C. school officials said the figure was misleading.

In a prepared statement Bennett praised the District for taking "a strong stand on educational improvement" and said "this is reflected in its educational progress." But he noted that the new data, like that in previous years, shows only a "weak" relationship between achievement and either spending or class size.

The National Education Association, the nation's largest teachers' union, criticized the state-by-state comparisons as "wall-chart follies [that] raise more questions than they answer." It noted that the federal share of public school spending has dropped from 7.4 percent to 6.5 since 1982, and suggested this may have "flattened out the curve of educational progress."

Janis Cromer, a spokeswoman for D.C. School Superintendent Floretta D. McKenzie, said the graduation rate or dropout figure was misleading because it was calculated mainly on the percentage of ninth graders in D.C. public schools graduating from D.C. schools four years later. She said this did not account properly for students who move from the city or switch to private schools.

ral areas "tend to drag down the statewide averages."

Since 1982 Maryland and Virginia have improved their rank on the SAT—Maryland going from ninth to sixth and Virginia from 11th to eighth. Maryland has improved its high school graduation rate to 12th best in the country, while Virginia's has slipped to 27th.

Virginia substantially improved its rank in both teachers' salaries and per pupil spending, but still lags behind the national average in both categories. Maryland continues to rank 10th in salaries—at $27,186 last year, while its per pupil spending rose from 10th highest to seventh.

Nationally, the public school graduation rate was 70.6 percent in 1985, down from 70.8 in 1984, but better than the 69.7 percent for 1982.

Bennett said the rise in test scores mainly reflected a nationwide move to higher academic standards.

The state-by-state results on the SAT and the American College Testing program exams, which are used mainly in the Midwest and South, combine the scores for students in public and private schools. But officials said national SAT reports show that both types of schools made similar gains.

In the District, the only jurisdiction for which separate public and private

ADASA

SUBSTANCE ABUSE

DISTRICT OF COLUMBIA

BRIEFING
FOR
COMMITTEE ON HUMAN SERVICES

SCOPE OF THE PROBLEM

OVERVIEW

63,534	Alcoholics or Problem Drinkers
16,000	Heroin Addicts
60,000	Polydrug Users (Cocaine, PCP, Marijuana)
12,955	Substance Abusers Treated Annually at ADASA

AMERICAN PSYCHIATRIC ASSOCIATION'S 1986

Significant Achievement Awards

Building Interpersonal and Academic Competence Among Troubled Inner-City Youths, City Lights, Washington, D.C.

At City Lights, an unusual day treatment program that combines classroom instruction with psychosocial therapy, poor black teenagers aged 12 to 22 with serious educational and emotional deficits experience a phenomenon that is new to them—success. For the 30 students at City Lights, located in a converted warehouse in a rundown section of Washington, D.C., failure and rejection have been the norm.

The typical student at City Lights is a 16-year-old ward of the city who reads at the third-grade level and has experienced multiple out-of-home placements in, for instance, residential treatment facilities, foster care, mental hospitals, or jails. Many students are diagnosed as suffering from borderline or antisocial personality disorder, character disorder, or depression, and many are involved in criminal activity. Students are referred to City Lights from the courts, community mental health centers, social service agencies, parole officers, and, less often, schools. By the time a youngster reaches City Lights, he has exhausted the goodwill of nearly everyone who has tried to help him.

City Lights is a private nonprofit corporation developed as a direct outgrowth of a 1977 lawsuit brought against the District of Columbia on behalf of handicapped wards of the D.C. Department of Human Services. Filed by the Children's Defense Fund, the Georgetown Juvenile Justice Clinic, and the Volunteer Attorney's Office, the suit charged that many wards had spent years in institutions solely because appropriate noninstitutional care was unavailable.

After the suit was resolved the Children's Defense Fund hired social worker Judith Tolmach, currently executive director of City Lights, to develop a community-based treatment program for emotionally and educationally handicapped youth. Initially the program was funded by private grants and foundations but now is supported mostly by annual contracts with the Mental Health Services Administration and Commission on Social Services of the District of Columbia.

What City Lights offers that the students' previous placements did not is a total therapeutic and educational environment. Each weekday students attend City Lights from 9:30 a.m. to 2:30 p.m. In the morning they attend three classes—English, independent living, and math. After taking a lunch break, each homeroom class meets with a teacher and social worker to discuss issues that affect the group. Later in the afternoon, students attend two more academic classes and a physical education class.

The curriculum used by the school is the Comprehensive Competencies Program developed by the Remediation and Training Institute located in Washington, D.C. The Comprehensive Competencies Program is an integrated computer-managed system of lessons that are taught using different mediums, including paper and pencil, computer, filmstrip, and cassette. The lessons range in sophistication from the nonreader level to the college level and in subject matter from life skills, such as comparison shopping and job interviewing skills, to basic math, social studies, and reading.

When a student enters the program, he is assessed on a battery of standardized tests. Based on the results, the school staff designs an individualized education program for him. During classes, each student works independently at his own pace while a teacher provides supervision and guidance. Classes consist of eight to ten students. Students must achieve a score of 80 percent correct on a computerized test in each curriculum area before moving to the next area. The school owns 12 personal computers.

The goals of the program vary with the needs and ability of each student; for some students the goal is rejoining their family and returning to public school; for others the goal is passing the general equivalency diploma examination or enrolling in vocational training; and for others the goal is developing the job and social skills necessary to gain an entry-level position in the workforce and live independently.

Extracurricular activities and field trips to museums and the John F. Kennedy Center for the Performing Arts are scheduled regularly to expand the students' sources of confidence and pride. With the help of a volunteer classical pianist, the students have formed a rhythm band and rock singing group. Students go horseback riding regularly at a public stable and are taught ice skating, tennis, and swimming by a recreation therapist.

Developing consistency and cohesion in the students' usually chaotic lives is a major part of treatment at City Lights. Each student has a case manager on staff who works with the student's family and the network of professionals involved with the student, such as his lawyer, physician, psychiatrist, parole officer, and social worker from the Department of Human Services. Further, the school is a therapeutic milieu where consistent interactions between staff and students promote students' healing and trust.

Each student participates in weekly individual or group therapy with a social worker at City Lights or a therapist outside the program. Some students receive both types of therapy, and some receive art therapy as well. The emphasis of therapy is on feelings that underlie behavior, here-and-now issues, decision making, and problem solving. The major goal of individual counseling is to help students build self-esteem and generate life choices.

Initially many new students cannot tolerate the intimacy required in therapy and become defensive, suspicious, and silent in a therapeutic encounter. Telephone therapy has been found to be an effective means of communicating with students who need to maintain a safe distance before developing a trusting relationship. Staff usually call these youngsters in the evening. In the first few calls they praise the students for their accomplishments during the school day, and eventually they are able to develop a therapeutic alliance that forms the basis for drawing the students into face-to-face therapy.

Since City Lights opened in 1982, a total of 30 students have graduated after an average stay of 24 months. The program's success can be measured by the 90 percent attendance rate, an average increase in reading level of 1.5 grades for every 100 hours of instruction, a voluntary drop-out rate of only 7 percent, and increased stability within natural or foster families. Even more impressive is the fact that only 10 percent of students have been returned to jails or hospitals.

Each student costs the program approximately $1,150 a month, less than the cost of incarceration in a juvenile detention center ($30,000 annually) or placement in a residential treatment facility ($30,000 to $50,000 annually).

In addition to the 30 full-time students at the City Lights day treatment program, 20 students between the ages of 16 and 26 participate in the school-to-work transition program called the Workplace, which was begun in 1985 with a three-year start-up grant from the U.S. Department of Education. The students work 20 hours a week at paid employment and attend classes 20 hours a week at the Workplace, located elsewhere in the city. After a 60-day evaluation period, the program places the students in jobs and provides a network of supportive services, such as vocational counseling and seminars, to help them cope with the demands of working and becoming independent.

City Lights employs a full-time staff of 15, a part-time staff of three, and three psychiatric or psychological consultants. The full-time staff consists of the executive director and founder Judith Tolmach, school principal Bert L'Homme, clinical director Annie Brown, a secretary, a fiscal officer, a vocational counselor, a recreation therapist, and eight teachers and social workers. The part-time staff includes a psychiatric resident from Children's Hospital National Medical Center, who spends one day a week at City Lights to provide therapy, psychiatric consultation, and pharmacological treatment. Assisting the staff are a large group of volunteers, including two foster grandparents, and high school and college student interns. Their energy and optimism are inspiring, Ms. Tolmach said. A 15-member interracial board of trustees advises the program.

Staff turnover has been surprisingly low considering the chronic manipulativeness and explosive behavior of the students. Staff attribute their tenacity to their close collaboration with each other fostered by the daily meetings they hold to discuss the students' progress and the bimonthly process group conducted by a psychologist from the A. K. Rice Institute. The multiracial staff's frank discussion of racial issues that arise in the treatment of an all-black student body has also contributed to staff cohesiveness.

But perhaps the most important reason that staff at City Lights stay on is that they feel good about helping young people teetering on the brink of chronic mental illness or habitual criminal activity to achieve their balance.

For more information about City Lights, contact Judith Tolmach, A.C.S.W., Executive Director, City Lights, 7 New York Avenue, N.E., Washington, D.C. 20002.

[Youth Policy, Dated Sept. 1986, Vol. 8, No. 9]

Work-Study in the Inner City—

Alternative education and job training can work together

In March, 1985, City Lights, a school for emotionally troubled black teenagers in Washington, D.C., began a federally funded work-study program for chronic high school truants. The project, called City Lights: The Workplace, has a three-year life and, without new funding, will fold in October, 1987. But The Workplace may deserve replication. Not only is the program meeting a real void in work-study for inner-city blacks, it's also well run and cost efficient.

City Lights: The Workplace combines academic remediation, group counseling and vocational placement in one program. The students spend roughly half their time in a learning center and the other half on the job. Fourteen- and 15-year-olds, because of child labor laws, work only 5 hours a week; they spend 25 hours in school. Some of the older students, however, spend about 25 hours a week on the job and 15 hours in school.

Though funding was provided by the U.S. Department of Education's Office of Special Education, the pilot project is also co-sponsored by the Remediation and Training Institute, which donated the use of its Learning Center, the Washington, D.C. Summer Youth Employment Program, which arranged job placements, and the D.C. Public Schools' Special Attendance branch, which referred students to the program.

The most significant feature of City Lights: The Workplace is its integration of education and job training for inner-city teenagers. Vocational rehabilitation is stressed from the beginning; students have a job counselor on staff and are assigned jobs that, usually, correlate with their interests and provide them with some skills training. As for the education component, City Lights uses a program of remediation that is fast becoming the most successful in its field.

The Comprehensive Competencies Program is an impressive system of computer-assisted instruction, developed by the Remediation and Training Institute in 1983 and now being marketed across the country. City Lights was one of the first sites to pilot CCP and is one of its original success stories. Principal Bert L'Homme calls himself a "convert" to computer-assisted instruction. When he was a teacher, he says, there was a conflict between those who taught as "technicians" and those who taught as "artists." "I considered myself an artist," says L'Homme.

"But when you're in a school downtown," he continues, "you don't have the luxury to think that way. You have to be efficient." And that's where CCP comes in.

L'Homme claims that he runs his school for $15 a day per student, an amount which leaves little room for inefficiency. Partnerships are the key to the program's low cost. Local businesses provide employment for the kids; city agencies refer students and handle job placement; and the Remediation and Training Institute has donated the use of its Learning Center and CCP equipment for the duration of the project.

So far, the program appears to be successful. Of his 30 students, L'Homme says, 25 will go back to the public schools this September with "upgraded basic skills and a positive job experience" behind them. Attendance for the learning center has been approximately 83-85 percent; job attendance rates are about 90 percent. For chronic school truants, these figures are impressive.

City Lights: The Workplace is only 85 percent funded for the upcoming school year, which may be its last. But over on New York Avenue, in a converted warehouse, the original City Lights day treatment program has finally established some financial stability for itself. That program is more psychoeducational, less jobs-oriented than The Workplace. It opened in 1983 in response to the *Bobby D. vs. Barry* lawsuit filed by the Children's Defense Fund in 1977 on behalf of handicapped wards of the D.C. Department of Human Services. At that time, there was no community-based treatment program in Washington, D.C., outside of institutions, for emotionally disturbed inner-city adolescents. Under the guidance of a social worker named Judith Tolmach, City Lights was born.

Various foundations provided funding for the program's first year, when there were 10 students enrolled. Having demonstrated its success, City Lights is now funded by tuition contracts from the District of Columbia's Mental Health Services Administration, the Commission on Social Services and the D.C. Public Schools. These agencies refer young people—all of whom have either been diagnosed as emotionally or mentally handicapped, delinquent or neglected, or chronically truant—to the program. There are now 30 students at a time. The agencies pay City Lights aproximately $1,040 a month per child, substantially less than the cost of institutional confinement in juvenile jails, mental hospitals or residential care—the only other options for City Lights students.

Tolmach, now the executive director of City Lights, has written that her program enrolls "adolescents who have been written off by the schools as unteachable, by the juvenile justice system as intractable, and by the mental health system as untreatable."

The original City Lights program uses the same CCP method of remediation that The Workplace uses. But the overall approach at the new project is less therapeutic an more transitional. The kids on New York Avenue L'Homme says, are emotionally disturbed. Those at Th

Too Late?

"The years between ages 16 and 22 are usually 'written off' by most mental health and education programs as 'too late' for significant change. It is not surprising that rates of institutionalization (in jails and mental hospitals) increase precipitously at this age when many youth lose the omnipotent fantasies of early adolescence and fill the emptiness with rage and depression. . . Late adolescence is an opportunity too often missed."

Judith Tolmach, executive director of City Lights
from the Journal of Clinical Child Psychology,
Fall, 1985.

Workplace have never been identified as such; but for some reason or another, they aren't going to school, and they're in danger of failing in the transition from school to work.

"This is a jobs program," L'Homme emphasizes. The students are given entry-level jobs in which they can develop real skills. And the jobs are not, as the principal says, "make-work." Students work at Boys' Clubs, university libraries and local hospitals, for example.

A number of the students have been offered part-time jobs as a result of good employment records this summer. Aquanette Harling, 14, for example, who works at Blackburn Cafeteria on the campus of Howard University, has been offered a job there this fall, every day from 4 to 8 for $3.80 an hour.

Still, L'Homme, and others like him, realize the necessary correlation between education and employability. The CCP method that City Lights uses focuses on an individual's potential to catch up on his own. Learners schedule their own time, work at their own pace, and realize specific goals when they master them themselves, without having to wait for teachers to mark papers or slower students to catch up. Much more responsibility for learning is placed with the students.

Why is there a need for schools like City Lights? "Some kids don't make it in a school with 3,000 other students," says Bert L'Homme. "The public education system basically uses one approach, and this doesn't always work."

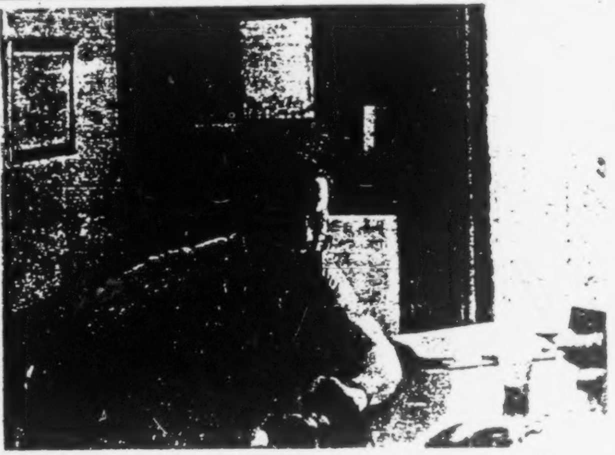
L'Homme cites figures from research conducted at the University of the District of Columbia that shows that 10-15 percent of D.C. public school students should be in a special services program. Only 2.5 percent actually are.

"Forty-four percent of the students in the D.C. Public Schools will drop out before they graduate," L'Homme notes. "We are raising a group of young people to be unemployed and jailed."

But L'Homme knows that working with the public school system is his program's only real chance for a long-term life. "We would, of course, prefer to be independent. But we know that our job is to be an agent of change within the community, not outside of it."

For alternative educators, often beset with expensive and poorly-run programs, the work-study efforts at City Lights may provide hope for success. ■

David Fleming



"Some kids don't make it in a school with 3,000 other students. The public education system basically uses one approach, and this doesn't always work."

—Bert L'Homme
principal, City Lights

No-Nonsense Remediation

A new approach to basic skills instruction, the Comprehensive Competencies Program, is taking off

After only 2 years of widespread use, the Comprehensive Competencies Program has become the fastest growing development in remedial education. The program, which uses state-of-the-art technology to teach basic skills, was designed in 1983 and implemented a year later. Dissemination of the program began in 1985; and by the end of June, 1986, there were 158 CCP Learning Centers in operation or being implemented across the country.

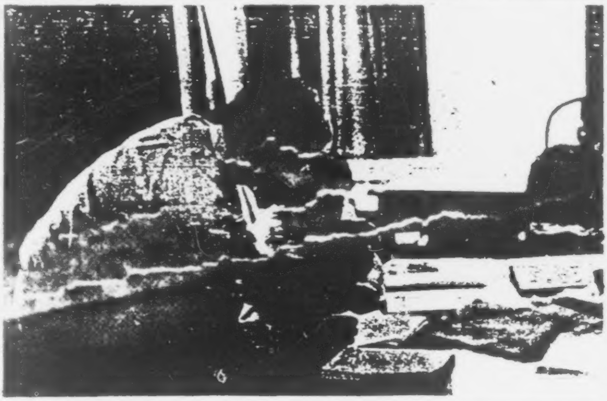
The program uses print, audiovisual and computer-based learning materials to cover "academic competencies," everything from elementary reading and arithmetic through high school and introductory college-level mathematics and humanities. "Functional competencies" include job getting and holding, consumer skills, citizenship, health, and community participation. Instruction, both by computer and pen-and-paper, is individualized and self-directed.

CCP was developed by the Remediation and Training Institute, with Ford Foundation support. It integrates the most successful educational approaches developed over the last several decades, including lessons learned from the educational programs of CETA and Job Corps. The dissemination of the program since 1984 has been phenomenal. Learning Centers are now in 28 states and the District of Columbia, situated in places where they are needed the most. Three of five centers, for example, are located in poor neighborhoods where the unemployment rate is above 10 percent.

CCP is used in regular secondary and post-secondary schools, adult basic education institutions and alternative schools (like City Lights in Washington, D.C.). It is also used by nationally-networked community-based organizations (like local Opportunities Industrialization Centers, National Urban League and SER: Jobs for Progress affiliates and 70001 franchises). In addition, many local Job Training Partnership Act agencies and correctional institutions are now using the program.

Grade-gain rates for CCP learners are substantial. According to the Remediation and Training Institute, which conducts an ongoing analysis of CCP use, students gained an average of 1.1 grades in reading in 31 hours of reading instruction and 1.6 grades in math in 28 math instructional hours. The commonly-accepted success standard for most basic skills instruction is one grade level gain in 100 hours of instruction in a subject. Put this way, CCP learners gained an average of 3.7 grades per 100 hours of reading instruction and 5.1 grades per 100 hours of math instruction. Even the most disadvantaged learners had impressive grade gain rates, according to Remediation and Training Institute research.

The program costs an average of $305 per grade gain per student, half the cost of a year in public school. The normal student, using CCP, gains a grade in every 27 hours of reading instruction and every 20 hours of math instruction.



Characteristics of CCP Learners

Learners	*Active in 1986*
Sex	
Male	43%
Female	57
Ethnic group	
White	36
Black	45
Hispanic	14
American Indian	1
Asian	3
Family status	
Single parent	24
Living alone or with friends	19
Married, spouse present	11
Living with parents or relatives	45
Percent weeks worked last 3 months	
10 or more	9
3-9	10
1-2	3
0	79

Setting of CCP Learning Centers

Alternative schools and adult education centers	25%
National community-based organizations	25
JTPA agencies/Job Corps	19
Post-secondary schools	12
Secondary and vocational public schools	11
Local community-based organizations	6
Private sector and unions	2
Corrections institutions	1

Who is CCP targeted to?

Target groups	*Percent centers with*
Primary students	20%
Secondary students	54
Dropouts	92
Young high school graduates	52
Older high school graduates	54
Post-secondary students	27
Poor	94
Limited English	20
Handicapped	39
Offender	51
Solo parents	62
Displaced workers	28

Multi-Purposes

"CCP use can be initiated and supported under the Job Training Partnership Act, vocational rehabilitation, vocational education and union or employer job training. It can be part of state and local workfare and welfare efforts or Work Incentive and Head Start programs. It can be supported by adult basic education, public and private secondary and post-secondary school budgets and special federal and state education programs. CCP learning can be financed with corrections and mental health resources available for community or institutional treatment. Economic development, housing and recreation programs provide other funding options. Instruction can also be supported by foundations, corporations and individual sponsors, or delivered on a fee-for-service basis paid by learners or parents."

Robert Taggart, director
Remediation and Training Institute
from "CCP: A Summary"

And students themselves give the program high marks. In a 1985 learner survey, four-fifths of respondents felt they were learning faster with CCP than in their last regular school.

That alone would be reason enough for those working in remediation or job training to look into CCP. But the program's cost-effective approach and businesslike organization is perhaps its biggest selling point.

According to Robert Taggart, the director of the Remediation and Training Institute, the average cost of the program per instructional hour was $13.09 per student in the first quarter of 1986. This includes the considerable capital costs of learning center equipment and software. A normal public school, Taggart has written, usually costs approximately $6.00 per hour of instruction.

But if average grade level gain is computed into this, the comparison tilts in the favor of CCP. In public school, the "normal" student gains one grade in each subject each year, at a cost of $720. But at CCP, says Taggart, the normal student gains one grade every 27 hours, in reading, and every 20 hours, in math, at an average cost of $305 per grade gain.

At its present growth rate, CCP may have another 100 users by next year. 70001, for example, has just received a $275,000 grant from the Ford Foundation to assist its local programs in financing CCP Learning Centers. The organization reported that 70001 programs which had used the system last year indicated that CCP had "significantly enhanced their ability to provide academic remediation." And that evaluation, coming from the field, is probably the best indicator of the program's success.

For more information on the Comprehensive Competencies Program, contact Robert Taggart, Director, Remediation and Training Institute, 1521 16th St., NW, Washington, D.C. 20036; (202) 667-6091. ■

David Fleming

Lights of the City

by Donna Guise

All through my morning classes, when I glanced up just to make sure that the quiet in the room was a result of concentrated work rather than catnapping, I kept catching the eyes of different students studying my face with perplexed expressions. Keith, in particular, looked as if it were taking all of his effort to keep from running over and rubbing my face just to see if the sunburn would come off. Although I had already countered a barrage of questions about how it happened, if it hurt, why I hadn't used suntan oil, (something I also kept asking myself), confusion was still evident. As with many things they needed to have the experience before they could have the understanding – and unluckily with red-hot sunburn, I doubted such would ever be the case.

Situations like this, however, just seem to highlight parallels between my students and myself. In fact, my entire existence for the past eight months has been a quest for understanding through experience. Before I joined the JVC, some very close friends advised that I didn't need to completely submerge myself in a culture in order to do positive work within it. They suggested, in fact, that I commute daily into the city, work intensely with urban youths, but return home to my upper-middle-class neighborhood before dark. I disagreed. Though I'm convinced that there are many good, dedicated teachers living in surburbia, I chose (at least for a year) a different route and thus far have no regrets. For me to begin to understand my students, I needed to make an effort to understand their environment, prostitutes, drug pushers, and roaches included.

Since September, I have been working as a teacher at City Lights, a day treatment program for severely emotionally disturbed adolescents. Initially, I considered that the name sounded more like a Fourteenth Street bar than an alternative high school; but the more I came to understand the program and its motivating values, the more I appreciate the value of its name. City Lights is a place of warmth and vision centered in one of Washington, D.C.'s worst neighborhoods. It is a program where previously chronic truants set a 95 percent attendance rate because they like to come to school. City Lights is a staff of dedicated professionals willing to cater to the individual growth of each of its thirty students. And it is a group of troubled adolescents who teach as much as they are taught.

Yet while these truisms are experienced on a more abstract plane, the concrete realities of City Lights are not entirely different. Last week, we held a school-wide spelling bee in which six students had the opportunity to compete both for individual prizes and for a homeroom victory party. Eliminations were fast and furious until only two students remained in the competition. After forty-five minutes of see-saw spelling, Pam missed a word, and Andre immediately rose in stature from big youngin' to academic scholar. His excitement, for a second, got the best of him, and he yelled in victory before the "ain't nothing" attitude reclaimed its superficial control; for one afternoon Andre was allowed to throw off the stigma of "troubled youth" and experience first place. As a witness to the event, I shared Andre's excitement. As his teacher, I shared his success. During the moment he experienced victory, I too, felt as if I had won a great prize. Of course, the trophy went home with him, but I was the witness of a corrected injustice.

Donna Guise

At my JVC orientation, I made the inane comment to one of my new housemates that I'd "never really thought much about social justice before." I consider it fortunate that she didn't hold it against me too much at the time, especially since I haven't thought about much else since. It is still difficult for me to appreciate the full impact of those two words, but as I watch the students at City Lights struggle to overcome issues of someone else's making, I witness some sort of justice prevailing. During my first week in the program, my supervisor told me not to expect to change all the students I worked with into Rhodes scholars. Instead, he told me to consider them as I would a pie without sugar – sprinkling sweetener on top would not compensate for a lack of an essential ingredient; the pie, as well as these youths, would never be quite right. Even as optimistic and energetic as I was back in September, the analogy left me with a pretty bleak view of things.

Eight months of work have given me a bit of perspective, however, and the pies I'm considering today are quite a bit different than the ones I looked at last fall; I realize that the sugar is missing, but some unique spices, Cool Whip, or a bit of Steve's ice cream can help to mask many flaws. The youths that I greet every morning and have come to care for so much have not been treated fairly. Their lives have been much more demanding than mine will ever be, and they have missed out on most of the positive, happy things that illuminate my childhood memories – this is the injustice of poverty, ignorance, and need.

Opportunity provides justice. At City Lights, the students are given a chance to attempt, to succeed, and to fail. Their pasts bring them to the program, but the hope of a more positive future keeps them attending. They are allowed to experience success, and with their experiences come the understanding that control of their lives is possible with the right choices.

Donna Guise graduated in 1986 from Loyola College in Baltimore, Maryland. She lives and works in Washington, D.C. Donna teaches at City Lights, a school for emotionally disturbed and delinquent adolescents.

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"There Ain't Nobody on My Side": A New Day Treatment Program for Black Urban Youth

Judith Tolmach
City Lights

Black, inner city, indigent youth present clinicians with an array of psychological, educational, social, economic, and behavioral problems that defy traditional treatment methods. City Lights is described as a comprehensive day treatment model that has the potential to succeed with high-risk youth. The program utilizes a self-paced computer-assisted education program within the context of a therapeutic community. Innovative strategies have been developed to accomplish both academic remediation and emotional development. Academic competence is seen as an essential component of psychological well-being.

Key words: adolescents, black youth, day treatment, psychoeducation program, community-based care

City Lights is a new day treatment program in Washington, DC that enrolls adolescents who have been written off by the schools as unteachable, by the juvenile justice system as intractable, and by the mental health system as untreatable. These are youth so successful at failure that they exhaust and discourage even the most idealistic among us who reach out to them with hope and one more chance. Because they fail consistently at home, at school and at work, such youths are rapidly moving to permanently disadvantaged status in our society (Gibbs, 1984).

City Lights is designed to withstand the assaults of troubled teenagers. In fact, in the two years since it opened, City Lights has achieved an attendance rate of 90%, despite a population of chronic truants. This high attendance rate, as well as the therapeutic and academic gains its high-risk youth have achieved, are a result of the program's commitment to a simple concept: creating an environment that guarantees the novelty of success to experts at failure.

Who are the Students?

The students at City Lights, all of whom are black, indigent adolescents from disorganized families in the District of Columbia, replicate the description of "the deprived" in the Carnegie Institute's 1979 study of school dropouts:

> For these youth, a combination of poverty, inadequate education, and weak psychological resources results in a litany of human and social disaster: high rates of criminal activity, drug and alcohol addiction, chronic unemployment, physical and mental illness, dependence on public welfare, and institutionalization. Society currently spends large sums on these youth – on the police, the courts, jails and prisons, and systems of probation and parole; on drug abuse programs; and on other forms of support. The real costs of deprivation are infinitely greater. The threat to urban life that lies in the high rates of violent street crime, much of it committed by deprived youth, the loss to the society of their potential contributions, are only the greatest of those hidden costs... . (Carnegie Council on Policy Studies in Higher Education, 1979, p. 249)

As Gibbs (1984) reported in a plea for new initiatives, "black youth in contemporary America can aptly be described as an endangered species" (p. 6). She reports numerous data that indicate that young blacks are worse off in the 1980s with regard to employment, delinquency, substance abuse, teenage pregnancy, and suicide than they were in the 1960s. Despite the alarming social cost of such neglect, shrinking resources and well-entrenched pessimism have resulted in few innovative attempts to alleviate the alienation of urban youth. The reluctance of mental health professionals to treat these adolescents can be attributed to the realization that such

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The author wishes to acknowledge the invaluable contribution of Annie Brown, Clinical Director, and Bert L'Homme, Principal, to the development and accomplishments of City Lights.

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youth cannot profit from clinical intervention alone; the "presenting problem" is inextricably linked to the family, the school, the community—each of which is part of the problem and must be part of the solution. Treatment requires collaborative efforts between professionals in different disciplines; the context of treatment must include not only the child and his family, but the social system with which they interact. Extrinsic factors play a role as significant in maintaining the dysfunctional behavior of troubled adolescents as intrinsic developmental factors "the person-centered variables" (Kraft & Demaio, 1982; Moos & Fuhr, 1982; Select Panel for the Promotion of Child Health, 1981).

Here is a case in point:

> Terry, a 17-year-old black male was referred to City Lights by his parole officer while he was still in juvenile detention for his fourth criminal charge, fencing stolen goods. Previous charges included car theft and breaking and entering. The second child born to a teen-aged mother, Terry lives in a household with his mother who is overwhelmed and exhausted by her troubles, four siblings, his sister's infant daughter and his mother's male companion who is periodically violent when drunk. Terry is of normal intelligence but reads at the third grade level due to infrequent school attendance and disruptive behavior which led to placement in a special education resource room in fifth grade. Terry exhibits a swaggering self-confidence that crumples in the classroom when his inability to perform is revealed. His moods alternate from bravado to profound sadness in rapid succession. In addition, Terry's family tacitly encourages his criminal pursuits which provide them with much-needed income.

In many respects, black urban youth such as Terry mirror the characteristics of a recently labeled psychiatric entity, "the young adult chronic patient." Bachrach (1984a) has described this growing population as fragile with a marked inability to cope with the demands of living, having poor functional adaptive skills, an inability to form stable relationships, and a multiplicity of symptoms that are exacerbated by frequent substance abuse (Bachrach, 1984a; Lamb, 1984). Further, such patients are demanding and manipulative individuals whose presence engenders strong negative feelings—anger, fear, helplessness. Pepper, Kirshner, and Ryglewicz (1981) indicate that such patients are mired in the transition to adult life and therefore unable to master the tasks of separation and individuation. It may seem premature to label City Lights students as "chronic," yet the typical student at 16 years of age has experienced at least three out-of-home placements (in residential treatment, foster care, mental hospital, or jail).

Certainly many troubled urban teenagers, such as those at City Lights, will grow up to swell the ranks of the adult chronically mentally ill population or the criminal justice system unless unique service programs intercept their downward path. The findings of a 1984 National Institute of Mental Health conference report support this gloomy prediction: "There is a heavy concentration of young adults who are now at risk for chronic mental illnesses, which results in an appreciable increase in the absolute number of homeless mentally ill individuals. Some part of the growth of the homeless mentally ill population also results from the inadequacies of the service system" (cited in Bachrach, 1984b, p. 515).

The Origins

City Lights was developed in response to a lawsuit, *Bobby D. v. Barry*, (*Bobby D. v. Barry*, C.A. No. Misc. 16–17 DC Superior Court August, 1980). In its recent report, *Unclaimed Children*, the Children's Defense Fund (CDF) revealed a startling, nationwide absence of services for adolescents (Knitzer, 1982). Older adolescents, who compose the largest percentage of children in institutional care, simply "mark time" until they can be transferred to adult mental hospitals or jails. Community-based aftercare programs to meet the needs of this age group are nearly nonexistent. Sadly, many of these children would never have been institutionalized in the first place if comprehensive programs had been available. The unnecessary institutionalization of children becomes more ominous when linked to the President's Commission on Mental Health (1978) report that indicated blacks under the age of 18 are twice as likely to be admitted to state and county mental hospitals as whites, who are treated more often on an outpatient basis.

Because the practice of institutionalizing adolescents in placements as far away as Texas, Massachusetts, and Florida had become so well-entrenched in the District of Columbia, CDF realized the need to go beyond legal remedies to ensure that these vulnerable children receive alternative, community-based care. In Feburary, 1981, as a continuation of its commitment to the *Bobby D.* children, CDF formulated a plan to establish City Lights to serve emotionally disturbed children in a noninstitutional setting and to serve too as a cost-effective model that can be replicated in other localities.

City Lights, which is housed in a converted warehouse, enrolls youth for whom the treatment of choice has been residential treatment in a pastoral setting remote from the confusion and temptation of big city life and equally remote from the realities to which such youth return.[1] All too frequently, such youth return to families who have lost interest in them, and to a city that has no programs—educational, vocational, or residential—to bridge the gap between institution and independence.

Initially, City Lights did not receive any public sector contracts; skepticism about a program for disturbed adolescents that eschews locks and medication forced us to underwrite our first year with revenue raised from 15 private foundations. The Commissioner on Social Services and the DC City Council also provided strong support and $75,000 in start-up funds. With 1 year of funding in the bank, City Lights solicited tuition-free referrals from various agencies, including St. Elizabeths Hospital and the public schools. In a year's time, our track record with these first 10 students earned public contracts for 30 youth at a monthly rate of $1040. Although this cost is high, it is far less than the cost of confinement in juvenile detention, mental hospitals, or residential treatment—the other options for City Lights students.

City Lights is a nonprofit corporation that is funded now by tuition contracts from the District of Columbia's Mental Health Services Administration, the Commission on Social Services (responsible for delinquent and neglected youth) and the DC Public Schools. A student is referred to City Lights by a school, court, community mental health center, social service, or parole officer. Students come with a variety of labels—borderline personality, antisocial personality, depression—but all have need of a total therapeutic environment. Over half of the current enrollment live with foster parents, the others live with a single parent, older siblings, or in a group home. The community-based treatment program serves 30 emotionally disturbed and delinquent teenagers between the ages of 12 and 22; it is the only psychoeducational program in the District for emotionally troubled teenagers over age 17, a group that borders on the fringes of adulthood and, usually, on the fringes of the mental health community's attention.

More Than A School

What kind of service program is successful with clients whose problems reflect an array of social, psychological, educational, vocational, and economic deficits? The literature is conclusive in its support of cohesive, multidisciplinary comprehensive care (Hobbs, 1979; Knitzer, 1982). Yet typically, troubled adolescents who are not institutionalized are offered a special education classroom and a referral to a community mental health center for counseling. It is not surprising that such narrowly conceived intervention fails to breach the extensive fortress of failure that typifies this population.

City Lights is more than a school and more than a school with additional clinical services. Because City Lights represents our students' "last chance" to turn away from failure, we are committed to meeting almost every need that arises; when we are not able to provide a required service (such as new eyeglasses, trombone lessons, or an after-school job), we act as advocates for our students in the community, and we teach them to become their own advocates, as well.

Learning to Learn

The typical student at City Lights is 16 years of age and has an average reading ability at the third grade level. Such youth are prime candidates to become high school dropouts; many already have long careers as hard-core truants by the time they reach junior high school. Yet without the cognitive competency to read and compute, a successful adaptation to adulthood is unlikely (Hobbs & Robinson, 1982).

As an outgrowth of our belief that competence can change behavior through increased self-esteem, impulse control, and opportunities for success (Shore & Massino, 1979), the education program at City Lights is enriched by self-paced computer-assisted instruction; optical scanners correct lessons in 15 seconds allowing students to evaluate their own learning, control their rate of progress, and receive frequent ego-building affirmation.

Committed to convincing our reluctant students that they *can* learn, City Lights installed nine computers and the Comprehensive Competencies Program (CCP), an integrated curriculum of paper and pencil lessons, software, cassettes, and film strips. Compiled from the most effective materials developed for CETA and Job Corps, CCP is an elaborate system of teaching materials that offers instruction that begins at the nonreader level and proceeds to college level; life skills (such as comparison shopping, application for food stamps, job interview skills) taught simultaneously with basic math, social studies, and reading; immediate positive reinforcement; objective evaluation of progress; and finally the pride of instrumental mastery.

For a student like Terry who was described earlier, CCP provides instruction on how to obtain a social security card written in third grade vocabulary. The subject matter befits his age, the reading level fits his ability, and the computer captures his interest. This unusual combination of factors is essential if students such as Terry are to succeed at school.

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[1] Unfortunately, the current allocation of federal and state dollars continues to encourage treatment in residential rather than day treatment settings (Knitzer, 1982).

Although CCP is an effective method for capturing the interest of reluctant students, its effectiveness is largely dependent on the therapeutic milieu that frames every aspect of a student's experience at City Lights. CCP offers no magic formula for overcoming academic deficits. If there is any magic, it is a trusting relationship that develops with painstaking slowness between students, teachers, and clinicians. Such a relationship, based on mutual respect, understanding, and optimism can repair the damaged ego – always a prerequisite for learning (Rothman, 1980).

Not Too Late

The years between ages 16 and 22 are usually "written off" by most mental health and education programs as "too late" for significant change. It is not surprising that rates of institutionalization (in jails and mental hospitals) increase precipitously at this age when many youth lose the omnipotent fantasies of early adolescence and fill the emptiness with rage and depression. Believing that late adolescence is an opportunity too often missed, the therapeutic milieu at City Lights is an eclectic combination of strategies designed to fill a treatment void.

> Belinda, 19, was born at St. Elizabeths Hospital to a schizophrenic mother who remained Belinda's legal guardian despite her frequent hospitalizations during which Belinda was placed with: a grandmother, a neighbor, and finally, a foster mother. When her foster mother died Belinda became "unmanageable" and was "temporarily" placed in an inpatient psychiatric unit where she stayed for 2 years while another placement was sought. Belinda clung to the hope of returning to her mother despite an adjudication of neglect requiring alternative placement. Finally, because her behavior deteriorated, Belinda was sent to a residential treatment program in Florida where she stayed for 3 years before coming to City Lights.

Belinda comes to City Lights each day resistant and defiant. "You all don't care about me, nobody does. Ain't nobody on my side." Realizing that her reluctance to cooperate reflects a justified fear of trust, Belinda's case manager (her primary therapist) and teacher meet with her each morning before school. Using Redl's (1959) Life Space Interviewing technique, staff allow Belinda to express her anger and sadness; she receives empathy, help with understanding her feelings, and coaching on behavior – all before entering the classroom. Such brief and timely "meetings" are available to City Lights students at any time, enabling fragile egos to borrow the strength they need to make it through a school day.

Sum of the Parts

In addition to therapy on demand, City Lights uses an eclectic approach to treatment and to behavior management. Individual therapy, group therapy, and family counseling are a part of every student's program, but these techniques are augmented by individually "packaged" treatment plans to remediate specific developmental deficits.

Milieu Therapy

Many students are not "ready" for individual or group therapy when they enter the program. Deeply distrustful of any human interaction, they resist attempts to reduce their protective defenses. We respect these defenses, realizing that only gradually can we hope to replace them with a realistic self-concept. Because the total environment at City Lights is carefully planned to provide constant therapeutic interactions, treatment begins as soon as students enter the program – even if individual therapy does not begin for many months – or ever. Every transaction provides an experience that is trustworthy, consistent, and respectful. Over time this predictable environment, in which communication is clear, becomes a medium for healing. Students learn to trust the program as prelude to trusting individuals within the program. Their ultimate ability to function as independent young adults is preceded by a carefully nurtured dependence on reliable caretakers – a critical aspect of childhood that they were denied.

Within the context of a therapeutic milieu, we use a variety of innovative strategies to keep attendance high and episodes of success frequent. Because we constantly try new methods of achieving these goals, this list of techniques is not definitive.

Music. A gospel singer and accomplished musician meets weekly with students to increase awareness of black culture, enhance vocal skills, and form a choir able to perform for community groups.

Ice skating. A staff social worker who is also a professional skater teaches ice skating as a way of helping students acquire self-discipline, delayed gratification, motor coordination, and cooperation with peers.

Therapeutic riding. Learning to master and control a horse helps students learn to control themselves and to anticipate the consequences of behavior.

Paid employment. All our students share a strong desire to earn money. Many are adept at accomplishing this through illegal means. Offering students who make academic and behavioral gains part-time employment is potent motivation for growth. Students earn the right to attend school half-day – an important step toward independence.

Telephone therapy. Individual therapy requires a degree of intimacy that is impossible for some students, causing unbearable anxiety – anxiety that is typically released through explosive behavior and profanity. Group therapy is not a suitable substitute for individual therapy if issues that need exploring are deeply private. Calling students on the telephone in the evening may not sound like a therapeutic technique, but it has produced surprising results. Initial calls are impersonal, just a "touching base" along with ample doses of praise for the smallest achievement that occurred during the day. Because sutdents are amazed that an adult would call on the phone to report something other than a criminal charge, these conversations have led to a therapeutic alliance and the eventual ability to tolerate face-to-face encounters. An unexpected bonus of "telephone therapy" has been a new relationship with the parent answering the phone who is understandably wary of talking to anyone about her child, since past encounters have been invariably negative. When a social worker, says, "I want to talk with Andy about the good day he had at school," there is a long silence of disbelief. After several such calls, the parent who had refused to meet with us is willing to reconsider her decision. This sequence of events has enabled us to offer practical guidance to troubled, resistant parents, which in turn has led to significant changes in relationships within families.

Community connections. Introducing students to the positive facets of urban life is another aspect of our attempt to help black youth develop a different self-image. The social, cultural, and spiritual programs offered by the city's black churches are explored in our leisure education program, which also includes Tae kwon do, physical fitness, tennis instruction, chess tournaments, and visits to museums and theatres.

Blurred boundaries. An important underlying principle of our day treatment program is the belief that education is therapeutic and therapy is education; therefore, the boundary between these two program components is intentionally blurred. For instance, class meeting, a daily part of the academic schedule, is a form of group therapy. A tutorial in the computer language LOGO, which allows student and teacher to work and talk privately over a period of months, has many aspects of individual therapy. This intentional absence of distinction between disciplines requires close collaboration and cohesion between educational staff and clinical staff. Daily 30-minute meetings to review each student's progress contribute to this essential cohesion. In addition, all staff attend a biweekly process group led by an outside consultant (trained in the Bion-Tavistock technique) who assists us in uncovering the unspoken and unconscious feelings that inhibit cohesion.

The Outcome

Fewer than ten students have "graduated" from City Lights in the 3 years that the school has been open. We are now in the process of developing an evaluation program that will measure both short-term changes and long-term outcomes with regard to institutionalization, ability to withstand crises, vocational history, and quality of life. Until the program's effectiveness has been confirmed by statistical measures, we can make only modest claims of success. These include the program's ability to keep emotionally disturbed chronic truants in school; reading and math levels that have increased an average of 1.5 grade levels in each school year, (a notable achievement for students whose records indicate many years of no progress at all); stability within natural and foster families that has dramatically reduced additional instituional placements; finally, the fact that only 10% of our students have been returned to hospitals or jails; students who dropped out of their own accord comprise an equally low 7%.

Although the results of an objective evaluation will not be available for several years, we have demonstrated in our first 3 years at City Lights that troubled black adolescents who have learned to be distrustful, fearful, mean, and sullen can learn to change, to trust, and to believe in their ability to succeed.

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[YOUTH POLICY, DATED NOVEMBER 1986, VOL. 8, NO. 11]

STATE OF YOUTH

Education

1. Americans will spend a total of $278.8 billion on education this year, an increase of $15.4 billion from 1984. National expenditures for schools and colleges represent 6.7 percent of the gross national product.

2. Spending for elementary and secondary education will amount to $170 billion, including $14 billion by private schools. Higher education costs will be $108.8 billion, including $38.1 billion for private institutions.

3. Average annual expenditure for each of the approximately 40 million public school students in the United States will be $4,203, up 5.2 percent from 1984.

Community Colleges

4. Between 1955 and 1985, the number of two-year community colleges has doubled from 611 to 1,222. Eighty-seven percent are public institutions, and 13 percent are independent.

5. In 1984-85, more than half of all first-time freshman (1.2 million students) attended two-year colleges. Women and minorities were more likely to attend community colleges than any other type of higher education institution.

Native Americans

6. About half of the nation's 1.4 milllion Indians live on reservations. Their land holdings total more than 53 million acres.

7. Unemployment runs as high as 70 percent on some reservations. One-quarter of the Indian workforce is seeking employment, and 27 percent of the total Indian population lives below the poverty line.

Youth Employment

8. 3.2 million 16- to 24-year-olds are officially out of work, nearly 38 percent of the nation's unemployed.

9. Despite a declining teen population, over 100,000 more teens were unemployed in June, 1986 than in June, 1985.

10. While 48 percent of white teenagers are working, only 30 percent of Hispanic and 27 percent of black teens have jobs.

Children in State Care

11. In California, the number of children placed monthly in emergency shelter care increased from 560 in 1981 to 3,280 children in 1985.

Sources:

1, 2 and 3—The U.S. Department of Education, Center for Education Statistics. 4 and 5—The American Association of Community and Junior Colleges. 6 and 7—The U.S. Department of the Interior, Bureau of Indian Affairs. 8, 9 and 10—*Youth Employment*, June, 1986. 11—U.S. House of Representatives, Select Committee on Children, Youth and Families.

Chairman MILLER. Thank you.
Mr. Davis.

STATEMENT OF THOMAS L. DAVIS, MENTAL HEALTH PROGRAM MANAGER, ALEXANDRIA MENTAL HEALTH CENTER/CHILDREN'S SERVICES, ALEXANDRIA, LA

Mr. DAVIS. Thank you, Mr. Chairman, Mr. Coats, and especially Mr. Holloway, for inviting me to appear before your committee today.

I come to you as a mental health practitioner working directly in the Community Mental Health Program in the largely rural area served by Alexandria Mental Health Center. Our children's service evolved from a child guidance center and survived as a distinct, specialized children's program despite demands on staff resources brought about by the growing needs of the chronically mentally ill adult population and by periodic state budget crises.

From time to time, failure of statistical measures of cost and efficiency to recognize fully the additional professional time required by the multi-faceted nature of children's problems has made the struggle more difficult. The basis of our survival has been strong community relationships and a long-term local administrative commitment to the preventive value of a children's program.

The strengths of our program lie in its development as a comprehensive system encompassing a range of service elements, instead of being limited to one specific element of outpatient services, and its long-term commitment to a philosophy of early intervention and treatment of children and adolescents while keeping them in the community and in their own homes whenever possible.

In treating the child in the community, focus has been on strengthening the natural support system present in the child's family and social environment. This approach involves extensive work with parents as well as schools and many other private and public resources.

In addition to its outpatient programs, the center and local school system in Rapides Parish work cooperatively together in a school-based program serving severely emotionally disturbed children. As an adjunct to this program, the two agencies jointly sponsor a therapeutic summer day camp for children enrolled in or under evaluation for the school program. Volunteers, local civic groups, and the local United Way contribute to the success of this program.

The center also has a contracted six-bed community home for emotionally disturbed adolescent males, a program that involves the interface of the mental health center, the contracting agency, the school system, and the vocational rehabilitation agency. The community home serves as an interim placement for reintegration of hospitalized youth back into the community and as a deterrent to hospitalization for others.

We have long identified the needs of children and families in our rural areas as a primary concern. While there are strengths in the rural areas, including the independence and pride of many rural residents, as well as informal networks of support found in the extended families, churches, and schools, there are also significant barriers in delivery of services to troubled rural youth and their families.

Availability of services in these areas is reduced as a result of the low population density, making it difficult to justify specialized programs, problems recruiting mental health and other professionals and the vulnerability of contributions by local governments with poor tax bases.

With the more specialized mental health services for children concentrated in relatively urban areas, there is a tendency for residents of our rural areas to underutilize their proportionate share of services. This is a result of a number of factors, including transportation problems, time lost from school or work, lack of awareness of the benefits and availability of services, and stigma regarding mental illness. Low wages and unemployment complicate the problems.

The distance has deterred systematic coordination of services just as it has created problems for families who need mental health services. This issue is currently being addressed on the State level through a broad-based effort at improving interagency coordination and developing a comprehensive community-based system of care, an initiative facilitated by funding through the Child and Adolescent Service System Program—CASSP.

It is clear that the challenge promulgated through the CASSP initiative, that emotionally disturbed children have access to a comprehensive community-based system of care that is responsive to the needs of the child and the family, can never be met by mental health services alone. Rather it requires a combination of efforts of many agencies, advocacy groups, consumers, Government officials, and legislators, all joining in a coordinated and effective manner to get the job done.

Your membership on this committee is evidence of your commitment. I am proud to be part of the process as we work together for our children and their future.

[Prepared statement of Thomas L. Davis follows:]

PREPARED STATEMENT OF THOMAS L. DAVIS, MSW, MENTAL HEALTH PROGRAM MANAGER, ALEXANDRIA MENTAL HEALTH CENTER/CHILDREN'S SERVICES, ALEXANDRIA, LA

Thank you Mr. Chairman and Mr. Coats, and especially Mr. Holloway, for inviting me to appear before your committee today, to address the important issues of children's mental health services.

I have been asked to share with you my local perspective on children's mental health services in the largely rural Central Louisiana area served by Alexandria Mental Health Center; I will identify strengths of our program, as well as problems and barriers encountered in service delivery to our rural population. I come to you as a mental health practitioner, having worked for the past thirteen years directly in the community mental health program in Central Louisiana.

Alexandria Mental Health Center is one of 45 full-time mental health Centers and 47 part-time outreach facilities forming a state-wide network of community mental health center programs directly operated by the Louisiana Department of Health and Human Resources, Office of Mental Health. These facilities, together with 55 contracted community programs and six state hospital-based programs operate as an interrelated system of services under the Department of Health and Human Resources. The community-based facilities and programs are administered through ten (10) state regions, with Alexandria Mental Health Center located in Region VI, consisting of 8 rural parishes in the Center of the State and comprising 7% of the State population. Alexandria, located in Rapides Parish, has a population of 56,000 and serves as the hub for commerce and medical and social services for the region. Alexandria Mental Health Center directly serves six parishes which total 5137 square miles. The total population of the six parish area is 221,510, approximately 61% of which reside in Rapides Parish.

The Children's Service of Alexandria Mental Health Center, serving children and adolescents under 18, is recognized as one of, if not the strongest children's program in the State. Established in 1954, initially as a Child Guidance Center, it actually preceded outpatient services for adults which were started by our local state hospital in 1959. Later, both services were placed under the auspices of the Community Mental Health Center, as these programs were developed by the State. The current staff of the Mental Health Center is composed of 8 administrative and support personnel, 11.8 adult clinicians, and 6.4 children clinicians.

Alexandria has maintained an intact, specialized Children's Mental Health Service in the face of increasing demands on staff resources over the past 20 years, brought about by the growing needs of the chronically mentally ill adult population and by periodic state budget crises. The survival of the program as a specialized unit is a result of strong community relationships and long-term commitment on the part of administrative personnel to children's programs. Justifying Children's programs has been on occasion particularly difficult when planners or legislators arbitrarily applied measures of cost and efficiency across various programs without taking into account what was required to achieve effective results among different client populations. In mental health services for children, work with the identified child "patient" is just the tip of the iceberg of interventions necessary to arrive at effective problem resolutions. For example "Bill" was referred to our Center by his pediatrician at eight years of age with complaints of hyperactivity. When we saw them, we learned that not only was Bill hyperactive from a medical standpoint, but also that he, his mother and younger brother were living in a small trailer without complete utilities, after having recently experienced the loss of his father. Quite understandably, his mother was also depressed. Our intervention has involved treatment of Bill, regular consultations with his classroom teacher, and extensive work with his mother, including treatment of her depression, assistance in obtaining subsidized housing, education and counseling regarding management of Bill's behavior, and assistance in obtaining the support of her extended family in meeting Bill's needs. We also put the mother in touch with other community resources and consulted with the local Boy's Club regarding how it could help Bill. Bill has remained in a regular classroom setting, and his mother is successfully employed, no longer receiving public assistance. The Center is currently in the process of helping parents organize a support group for parents of hyperactive children. Bill's case is illustrative of the fact that effective work with children requires a multi-faceted approach, involving parents, school, and a myriad of other resources. The professional time involved in providing these services is not always apparent on statistical reports.

Our administrative personnel in supporting the Children's Service program have maintained that it is prevention at least at the secondary level, and contend that early intervention with troubled children and their families can reap long term benefits by alleviating or reducing impairment in adult life, enabling individuals to become more independent and productive members of their communities. Expanding the preventive concept further, one can speculate on the potential benefits to younger or yet unborn siblings as well as future offspring of troubled children as a result of the reduction or resolution of problems brought about by an early intervention with the family.

The Children's Service has been developed as a comprehensive system encompassing a range of service elements, rather than being limited to a specific element of service. Currently in place are formalized programs of outpatient mental health services to children and their families, consultation and education services to the community, school-based consultation and treatment services for severely emotionally disturbed children, a therapeutic summer day camp for emotionally disturbed children, and a community home for emotionally disturbed adolescent boys.

Throughout the years, the Center has been committed to a philosophy of early intervention and treatment of children and adolescents in the community and in their own homes. Application of this philosophy was evidenced in the fact that the Region had the lowest per capita client population in the Gary W. lawsuit, which involved placement of children in treatment facilities in Texas in the 1960's and 70's. Clinical, administrative, and clerical staff remain committed to keeping children in their own homes whenever possible. Psychiatric hospitalization is considered only in the most severe cases of emotional disturbance. In fiscal year 1985-86, two children and seventeen adolescents were admitted to State hospitals at the recommendation of the Children's Service. A total of 312 children were admitted to the Children's Service caseload during the same time period. Six additional adolescents from the catchment area were admitted to state psychiatric hospitals without the recommendation of the mental health center.

In treating the child in the community, our focus has been strengthening the natural support system present in the child's family and social environment. Parents are engaged in a partnership with the Center in all aspects of planning and service delivery, and in view of the fact that the school is a significant part of the child's environment, contact is routinely made with teachers and other school persons. For severely emotionally disturbed children, the Children's Service and local school system work cooperatively together in a school-based treatment program. As an adjunct to this program, the two agencies jointly sponsor a therapeutic summer day camp for children enrolled in or under evaluation for the school program. Volunteers, local civic groups, and the local United Way also contribute to the success of these programs.

On the State level, there has been active, broad-based support by a full range of state child service agencies and child advocacy groups, as well as parents and concerned citizens for the development of a comprehensive community-based system of care for emotionally disturbed children, this intiative facilitated by funding through the Child and Adolescent Service System program (CASSP). As part of this process, the Mental Health Association of Louisiana and the Louisiana Alliance for the Mentally Ill are cooperating in the development across the state of support groups for parents of children with emotional problems.

Before looking at some of the problems I have observed relative to the delivery of mental health services in our rural areas, I want to first point out that I am not discounting the advantages of rural lifestyle. Residents of rural areas are often independent, proud, and patriotic people who try to instill these qualities in their children. There is often the presence of an extended family to provide support in time of need and to establish for the child a strong sense of identity. Also, in many cases, the churches and schools form informal networks of support in rural communities. However, it should not be overlooked that there are troubled children out there, and that there are unique difficulties and frustrations involved in serving them.

Generally speaking, the availability of various services is reduced in the rural areas, as the low population density makes it difficult to financially justify many specialized programs. This is true for private as well as public providers of service. Until recently, there were no private treatment facilities available for children in our vicinity, and local psychiatrists routinely referred children to our center. In most of the rural areas, the only available option is referral to the Mental Health Center. Also recruiting mental health professionals in rural areas is very difficult, a problem compounded by comparatively low pay scales. Further, due to the poor tax base in many rural areas, contributions by local governments for community programs are adversely affected by poor economic conditions as well as by state budget reductions. For example, as a result of our state's current economic problems, which have resulted in significant budget cuts across our State agencies, several local governments in our region who have made small contributions in support of community-based mental health services have been forced to withdraw these funds.

With the more specialized mental health services for children concentrated in relatively "urban" areas, there is a tendency for residents of rural parishes to under-utilize their proportionate share of services. Distance is a significant barrier to utilization of services, because of lack of reliable transportation or any transportation at all, and because of time loss from work or school. Low wages and unemployment are complicating factors. The distance has deterred systematic coordination of services, just as it has created problems for families who need mental health services. Further, residents of rural parishes tend to be less aware of the emotional aspects of problems and the benefits and availability of mental health services.

In some areas, stigma regarding mental illness prohibits persons from seeking needed help. Those factors combined result in very few self-referrals, more skipped appointments, and poor follow-through with treatment recommendations. There is a tendency among some child service agencies to delay referral to the mental health center until the child and family are in a severe crisis because of the awareness of the burden placed on the family in obtaining these services. The overall result is that many of these children are unserved; others are underserved or not served in a timely manner.

Our Mental Health Center staff has long identified improving services to emotionally disturbed children in the rural parishes as priority concern. However, many of the same barriers which have prevented rural residents from utilizing urban resources have interfered with delivering services to the rural area. Two years ago, we allocated one clinician to work with children one day each week in a rural outreach clinic serving three parishes separated from us by poor roads and a large expanse of water. Also we have requested CASSP funding for a local demonstration project which seeks to build on the strengths and existing resources in the rural parishes by developing a community-based system of care that combines an interagency service network with the strong, natural support networks found in most rural communities. We have proposed that the school be the point of entry into the system and the locus for service coordination. We have been informed that our proposal has received Peer Review approval.

While there have been indications of significant progress over the years in our efforts to improve mental health services for our children, we still have a long way to go toward meeting the challenge promulgated through the CASSP initiative that emotionally disturbed children have access to a comprehensive community-based system of care that is responsive to the needs of the child and the family. We are aware of many deficiencies and needs that cannot be met with our present allocation of resources. It is clear that the challenge can never be met by mental health services alone. Rather, it requires a combination of many agencies, advocacy groups, consumers, government officials and legislators, all joining in a coordinated and effective manner to get the job done. Your membership on this committee is evidence of your commitment. I am proud to be a part of this process as we all work together for our children and their futures.

Chairman MILLER. Thank you.
Mr. Feltman.

STATEMENT OF RANDALL FELTMAN, PROGRAM MANAGER, CHILDREN'S SERVICES DEMONSTRATION PROJECT, VENTURA COUNTY MENTAL HEALTH SERVICES, VENTURA, CA

Mr. FELTMAN. On behalf of the many people involved in this project in California, I thank you for this opportunity to share our experience and success.

The Ventura Model is a new way of doing business for public mental health agencies and communities interested in helping their highest risk and most vulnerable children live independent and productive lives. Most important to our success, the Ventura Model unites advocates for better children's services with persons responsible for public agency cost containment.

Ventura County, California, spent seven years developing this model comprehensive interagency children's mental health system. Ventura County's recognized success led to its selection in 1984 by the legislature as a demonstration project to develop and evaluate an innovative, comprehensive, local mental health system for children. A system of care is now defined and fully operational under the Ventura Model. It provides a planning mechanism that fosters continual modification and improvement.

The Ventura Model has five important characteristics. Number one, the minimum client population is specified for the public sector. The target population is multi-problemed children and youth separated or at imminent risk of separation from their families who are identified as mentally disordered juvenile offenders, mentally disordered court dependents, seriously emotionally disturbed special education students, and State hospital candidates and residents.

California's current financial liability for its 10,000 identified target population children exceeds $240 million annually in residential and State hospital costs alone, and these children's experience puts them at the highest risk of remaining public charges for their entire lives.

The second characteristic: Family unity and local treatment are the primary goals. It is in the public's best interest to keep high-risk children in their own homes and to maximize parental responsibility and treat them in their own communities. If removal is required, local treatment maximizes family participation and minimizes length of stay in costly and restrictive residential facilities and hospitals.

Three: The system provides alternatives to out-of-home placement and hospitalization. An effective system requires graduated levels which provide necessary and appropriate treatment in the least restrictive setting. A continuum also provides cost advantages since highly intrusive and restrictive care is more expensive. The Model's programs fill the gap between once-a-week office visits and hospital placement.

The fourth characteristic: Mental health services are integrated with home, schools, juvenile justice, and social services environments. Combining or blending agency expertise in resources to treat the full range of problems that put a child at risk is more effective. Collaboration means the service needs of the whole child rather than parallel efforts by separate agencies to treat parts of a child's problem.

Blending funds across agencies provides leverage for single agency sources of funds and increases program options. Thus, mental health services are integrated with social services, special education, and juvenile justice. Private sector involvement and participation is solicited, coordinated, and focused on public sector children.

The final characteristic: Systems level evaluation analyzes the benefits for the child, family, and community and costs incurred by the public sector. The mental health data base monitors outcomes for the child over time and across agency environments. The effectiveness of all interagency programs is measured by the number of children who stay in or are returned to home and to public school, lower recidivism among juvenile offenders, and reductions in residential placements and hospitalizations. Client costs for state hospital, AFDC/FC group homes, and residential nonpublic schools are reported.

What are the results? The benefits of the Ventura Model, after 18 months of operation, are dramatic. The project has lowered the rate at which children are separated from their family and is offsetting more than 50 percent of its costs through just short-term reductions in other recoverable state general fund expenditures.

Specifically, Ventura County has reduced state hospital use to 25 percent of its previous 1980–81 level, which is also 25 percent of the statewide average for children and youth. To date, annual savings average $428,000, offsetting 31 percent of the project's yearly cost.

Two, since June of 1985, Ventura has reduced out-of-county, court-ordered juvenile justice and social service placements from 89 to 48 children, a 46 percent reduction.

Three, since the project began in 1985, AFDC/FC placement costs have declined 11 percent in Ventura County, an annual savings of $226,000, offsetting 16 percent of the project's cost. With statewide implementation, the projected savings in AFDC/FC costs alone would be $22 million.

Four, in 1985/86, with the implementation of the Ventura Model, reincarceration of mentally disordered juvenile offenders was reduced 47 percent, a potential savings of $385,500.

Five, Ventura County currently has only four handicapped special education pupils placed pursuant to Public Law 94–142 in residential nonpublic school placement. This is 20 percent of the statewide average. This difference in public sector costs between Ventura County and the statewide average equals $480,000 per year. These results demonstrate concrete and measurable advantages to both the child and the taxpayer.

In closing, the hope and request of Ventura County is that this committee would consider action to add funding to CASSP for five to ten regionally distributed local mental health service demonstration projects throughout the country and tie them together with technical assistance and evaluation. This could show for the other states and the nation what Ventura County has demonstrated in California. Local mental health services integrated and in partnership with special education, juvenile justice, social services, and the private sector, make a life-shaping positive difference in the lives of children and pay for a large part of their cost by reductions in hospital and residential care.

Thank you.

[Prepared statement of Randall Feltman follows:]

Prepared Statement of Randall Feltman, MSW, Project Manager, Children's Services Demonstration Project, Ventura County Mental Health Services, Ventura, CA

The Ventura Model is a new way of doing business for public mental health agencies and communities interested in helping their highest risk and most vulnerable children live independent and productive lives. The Model builds on the Community Mental Health Services Act signed by President Kennedy. It adds what we have learned in the past 25 years and clearly focuses public policy and planning on the future as we look toward the year 2000. Most important to our success, the Ventura Model unites advocates of better children's services with persons responsible for public agency cost containment.

Ventura County, California spent seven years developing this model comprehensive inter-agency children's mental health system. In 1980, during the difficult post-Proposition 13 period in California, local initiative and leadership came from a newly elected Board of Supervisors member, Susan Lacey, and a Juvenile Court Judge, Steven Stone, who sought better, more efficient ways of delivering necessary public services to Ventura's children.

Ventura County's recognized success toward this goal lead to its selection in 1984 by the Legislature (AB3920 by Assemblywoman Cathie Wright) as a demonstration project to develop and evaluate an innovative, comprehensive local children's mental health system. Assemblywoman Wright's goal was to improve inadequate and diffuse, independent, agency-oriented, unaccountable children's mental health programs. Assemblyman Bruce Bronzan joined Assemblywoman Wright in a powerful bipartisan coalition of support. The Project has been extended into its third year with the signing of AB 66 by Governor Deukmejian.

A system of care is fully defined and operational under the Ventura Model. It provides a planning mechanism that fosters continual modification and improvement. The political support for the Ventura Model across California is strong, unprecedented for a mental health service, and intensifying. AB377 (Wright and Bronzan) underscores this support as it seeks to expand the Ventura Model throughout California. It has passed the California Assembly and is progressing well through the Senate toward the Governor's desk in August. We have every indication he will sign it if given the opportunity.

The Ventura Model has five important characteristics:

1. THE MINIMUM CLIENT POPULATION IS SPECIFIED FOR THE PUBLIC SECTOR.

Treatment is not given on a "first come, first served," basis. *Instead, the target population is multi-problem children and youth separated or at imminent risk of separation from their families who are identified as mentally disordered juvenile offenders, mentally disordered court dependents, seriously emotionally disturbed special education students, and state hospital candidates and residents.* When removed from their families, the State often has legal responsibility for, and physical custody of, these children. California's financial liability for its 10,000 identified target population children exceeds $240 million annually in residential and state hospital costs, not including local mental health costs. These children's experience also puts them at at the highest risk of remaining public charges for their entire lives.

2. FAMILY UNITY AND LOCAL TREATMENT ARE THE PRIMARY GOALS.

It is in the public's best interest to keep high risk children in their own homes to maximize parental responsibility, and treat them in their own communities. If removal is required, local treatment minimizes length of stay in costly and restrictive residential facilities and hospitals. *Thus, home-based and local programs provide maximum support to the family, or if separated, returns the child to the family as soon as possible.*

3. THE SYSTEM PROVIDES ALTERNATIVES TO OUT OF HOME PLACEMENT AND HOSPITALIZATION.

An effective treatment system requires graduated levels which provide necessary and appropriate, least intrusive treatment, in the least restrictive setting. A continuum of service also provides cost advantages since highly intrusive and restrictive care is more expensive. A child's state hospital bed costs $95,000 per year. Residential care costs between $25,000 and $50,000 per year. The Model's programs fill the gap between once a week office visits and hospital placement. *All Ventura County children with public agency involvement and at risk of out of home placement are screened by local mental health and linked with appropriate, least intrusive treatment in the least restrictive setting.*

4. MENTAL HEALTH SERVICES ARE INTEGRATED WITH HOME, SCHOOLS, JUVENILE JUSTICE, AND SOCIAL SERVICE ENVIRONMENTS.

Combining or blending agency expertise and resources to treat the full range of problems that put the child at risk is more effective. Collaboration meets the service needs of the "whole" child, rather than parallel efforts by separate agencies to treat parts of a child's problem. Blending funds across agencies provides leverage for single agency sources of funds and increases program options. *Thus, mental health services are integrated with social services, special education, and juvenile justice. All new programs blend services, staff, and funding across agencies. Parallel services are eliminated and the result is a community-based, integrated, interagency continuum of service. Written, formal interagency agreements provide clear expectations in all areas between agencies. Private sector involvement and participation is solicited, coordinated, and focused on public sector children.*

5. SYSTEMS LEVEL EVALUATION ANALYZES BENEFITS FOR THE CHILD, FAMILY, AND COMMUNITY, AND COSTS INCURRED BY THE PUBLIC SECTOR.

Community based programs should provide higher client benefits and significantly reduce residential and hospital costs. Thus, the mental health data base monitors outcomes for a child over time and across interagency environments. The effectiveness of all interagency programs is also measured by the number of children who stay in or are returned to the home and public school, lower recidivism among juvenile offenders, and reductions in residential placements and hospitalizations. Client costs for the state hospital, AFDC-FC group homes, and residential non-public schools are reported.

WHAT ARE THE RESULTS?

The benefit of the Ventura Model and the local mental health services provided is shown in the results presented in our most recent report after 18 months of operation. The results are dramatic. The Project has lowered the rate at which children are separated from their family and enabled them to return to their home and public school sooner. Moreover, the Project is offsetting more than 50% of its costs through just short-term reductions in other recoverable state general fund expenditures.

1. Ventura County has reduced state hospital use to 25% of its previous 1980-81 level which is also 25% of the statewide average for children and youth. To date, the annual savings average $428,000, offsetting 31% of the Project's yearly cost. California could save about $17 million a year in state hospital costs with the Ventura Model.
2. Since June 1985, Ventura has reduced out-of-county, court-ordered juvenile justice and social services placements from 89 to 48 children, a 46% reduction.
3. Since 1978, AFDC-FC payments for court ordered placements in residential facilities have increased steadily in California and Ventura County by 15% per year. However, since the Project began in 1985, placements have declined 11% in Ventura County (an annual savings of $226,000) offsetting 16% of the Project's cost. With ongoing refinements in the system of care, additional savings will be reported in the upcoming two year report. With statewide implementation, the projected savings in AFDC-FC costs would be about $22,000,000.
4. In 1983-84, prior to the Project, Ventura County spent, based on the daily rate, about $815,800 on reincarcerations for 140 juveniles who reoffended *after* being incarcerated in Colston Youth Center. In 1985-86, with the implementation of the Ventura Model, reincarcerations were reduced 47%, a potential County savings of $385,500. *The results suggest that treatment can reduce recidivism, an important social goal, and one with a long term impact on the need to construct juvenile detention facilities, and eventually adult prisons.*
5. Ventura County currently has 4 handicapped special education pupils placed pursuant to an Individual Education Plan in a residential, non-public school placement. This is 20% of the statewide average of 20. The average statewide cost per placement is $30,000. The difference in public sector costs between Ventura County and the statewide average of 16 placements equals $480,000 per year.

These results demonstrate concrete and measurable advantages to the child and taxpayer

The committee has been provided with a copy of our most recent 18 month report, our written interagency agreements, and other project materials. In addition we have provided copies of AB3920, AB66 and AB377.

In closing, the hope and request of Ventura County is that this committee would support the Child and Adolescent Services System Project of the National Institute of Mental Health (CASSP). If Congress would add funding for five to ten regionally distributed local mental health service demonstration projects throughout the country and tie them together with technical assistance and evaluation we could show for other States and the Nation what Ventura County has demonstrated in California. Local Mental Health Services, integrated and in partnership with special education, juvenile justice, social services and the private sector make a life-shaping positive difference in the lives of children and pay for a large part of their cost by reductions in hospital and residential costs.

Chairman MILLER. Thank you.
Ms. Shanley.

STATEMENT OF JUDITH A. SHANLEY, ASSISTANT COMMISSIONER, ERIE COUNTY DEPARTMENT OF MENTAL HEALTH, BUFFALO, NY

Ms. SHANLEY. My name is Judy Shanley. I am the assistant commissioner of the Erie County Department of Mental Health, which is in Buffalo, New York. I am an agent of government. I am the bureaucracy.

The focus of my testimony then will be more on the planning, organization, and financing of children's services by this local governmental unit in the State of New York.

Given some of the estimate of need factors that were identified in the earlier panel, we figure there are some 275,000 adolescents in Erie County 18 years of age or less and, of that, some 28,000 are apt to be in need of mental health services annually. In 1986, we served some 6,000 children.

The prevalent rationalization for the failure of the mental health system to meet estimated need has been the level of service availability provided through other auspices such as the Department of Social Services, Division for Youth, education systems, and family court. Mental health planners must be more exact in defining the numbers and kinds of children in specific need of services.

Children's Services as a component of the mental health service system in Erie County currently has a waiting list of some 600 children for outpatient mental health services. A period of one to two months on a waiting list before entrance to service is to be expected. Whereas several years ago the predominant source of referral for mental health services came from schools and pediatricians, today the most frequent sources of referral are the Department of Social Services and the court systems.

There is no acute care, psychiatric, inpatient unit for children in Erie County. The long-term unit operated by the state serves eight western New York counties, has a certified capacity of 56, and has had an average census closer to 75 for most of this year.

The lack of sufficient capacity in outpatient programs results in the children on waiting lists deteriorating between the time of referral and the time of admission to care. The lack of inpatient capacity results in the admission of seriously mentally ill children to pediatric units or to adult psychiatric units, neither of which are a suitable treatment environment for these children.

Recent data in Erie County suggest that we will have a twofold increase from 1986 to 1987 in the number of children under 18 who present for psychiatric admission at the emergency room of our county hospital when there is no unit there for them. The increase is from 157 for the total year of 1986 to 164 in the first six months of 1987. This extraordinary increase in demand for the highest level of care for children is neither well anticipated nor well understood in our County Hall. The degree of alarm felt was caused only by the degree of frustration at our incapacity to conduct real analysis and achieve real understanding of what is going on.

I would like to look at some system issues that we suggest are causing this new wave of children seeking hospitalization. The last decade has seen a significant thrust in social policy based on the premise that children should remain in their natural settings, both school and home. We support that thrust.

One of the impacts of the Child Welfare Reform Act in Erie County is a 30 percent reduction in foster care placements. The children being placed are more severely disabled and more apt to require institutional care rather than residential care.

The preventive programs financed by the Department of Social Services primarily intend to prevent foster care placement, not mental illness. The resultant focus by the Department of Social Services on open and founded cases often seriously curtails a child's continued care in the mental health programs.

The entrance of PINS Diversion in New York State, which is the family court placement of children in need of supervision, has resulted in a real press away from taking kids out of their homes and away from their families, with the expectation that mental health services can impact on the problems of these children and their dysfunctional families. This program in its first three years in New York State did not require the involvement of the mental health programs and the mental health system.

The mental retardation developmental disability system has also tightened the admission criteria to its system, again removing a previous resource for children in need of service, a particular problem in Erie County that has resulted from the transfer of New York City juveniles into Erie County Division for Youth facilities and has reduced even further the number and range of potential placement options for children.

These policy changes in other areas of the children's service sector were not planned in cooperation with the mental health sector such that we could be prepared for the kinds of children and their unique needs, much less have in place the needed treatment options.

In some ways we are mirroring what we did with the chronically mentally ill when we deinstitutionalized in the late 1960's and early 1970's. We are taking people out of one system before we have really put in place what we know are the preferred options. This must be coupled with the increasingly sophisticated citizen demand for due process and full substantiation of allegations in the legal processes of family court, probation, social services, school systems.

All this leads to an increasing demand on the mental health system, which has no mandated criteria for who should be served. Our largest children's treatment service provider has an active case load of 900 children. With their involvement in terms of social services and serving sexually abused children, their caseload of 900 is almost one third sexual abuse/sexual assault cases. The related court time required has increased four times from last year in terms of the amount of time that clinicians are spending in court giving expert testimony as we end up with a legal system that is very, very fast learning how to protect perpetrators.

The profile of these children shows that they are younger, more violent, and more disturbed. I hear again the echo from Erie

County of all of the other areas of this country that we have heard from today. They are more likely to be suicidal, more likely to be involved with alcohol and drugs, and they are more likely to come from single-parent families.

While single-parent families constitute 24 percent of the family units in Erie County today, they represent 70 percent of the petitioners to family court. These children and their families are more likely to need more intensive clinical services and need to be served by several agencies at one time. This demands more coordination of services. Children and their families are more likely to miss appointments, not engage in the treatment plan regimen, and are more likely to drop out of care. If they drop out of care, they are more likely to surface again shortly in either the same sector or another sector of the children's service world.

The uncoordinated involvement of these multiple sectors in providing service to children must be considered a principal cause of the ineffective, discontinuous, unresponsive care to the children and is anathema to the meaning of the word "system."

At the direct care level, the various sector operate in such independence and isolation from each other that nobody, not the psychiatrist or the social worker, nor the teacher, nor the probation officer, least of all the poor parent, can put it together in a way that brings the extraordinary public resources available to bear on the whole child and his or her problems.

The expected outcome of the human service institutions, what they consider a success, can be different, depending on which sector the child entered. Where the Department of Social Services wants to prevent placement and to close an abuse or sexual assault case, Mental Health wants to keep that case open to work with the child to assure resolution of interpersonal issues and maximize the potential that that child could develop into an adult able to have relationships.

Whereas Probation is focused on dismissing a petition by parents to remove children from the home, Mental Health is focused on identifying and addressing the family dynamics that led parents to that degree of powerlessness that court action was the only resource they saw to help them out.

In some of the areas of greatest unmet need there is administrative chaos and very significant expenditure of public dollars in the aggregate. Currently, the duplicative expenditure on assessment alone can result in children being assessed by all of these different systems. There is no comprehensive, integrated method for assessment that looks holistically at the child as a single system, that has social, familial, educational, and psychiatric problems.

The specialized sources of authority for the different children's service sectors make integration of service planning at an individual or systems level not possible in any real way. There is no management information system that tracks the highly troubled youth and families as they are processed through multiple sectors.

The attention to the confidentiality issues and the desire to not have a child's record follow them into adulthood becomes a true barrier to continuity of care yet remains an ethical dilemma. In Erie County, we attempted to address this diversity of auspice by establishing the Erie County Child Mental Health Consortium made up of all major stakeholders in services to children, from voluntary, government, health, education, courts, and social services. The Commissioner of Mental Health has specifically delegated a systemwide planning role to this body. The other auspices have not delegated similar planning authority and responsibility to the consortium. Hence, the capacity to assure implementation of plans by all service sectors has not been realized.

I have begun to introduce the next topic of my testimony, and that is the organization of children's mental health services. The capacity to pull together these disparate auspices on behalf of children currently rests with the personal capacities of skilled clinicians or particularly innovative Government officials. There is no system design directed at the comprehensive needs of children and the modular elements of service that need to be brought in and out as the intervention process occurs.

The failure to reconcile the competing concerns of the various sectors involved in children's services results in a level of fragmentation, or duplication or unmet needs, or unsuccessful outcomes that cannot even be measured as we try to observe the current way we do business.

There is a consensus in many parts of New York State and Erie County that the children's mental health system must design a comprehensive assessment tool and establish referral policies and practice to assure clear identification of needs and access to a full range of services. The use by children's mental health needs of the other than mental health sectors must be carefully integrated, and a management information system with a child tracking capacity should be present. We suggest that a central entry point be used for children in the community needing mental health services, as identified by the various other sectors.

The attempt to address children's mental health services cannot occur in isolation or as a response to a new wave demand without integrating these other sectors. The county departments of mental health, social services, and division for youth are responsible for coordinating services across 33 school districts in Erie County alone. Flexibility exists at the county level to organize and arrange services that are responsive to unique needs of children in communities within Erie County while being consistent with state mandates.

It is possible at this local level to identify and propose resolution of the apparent conflicts, inconsistencies, gaps, and areas of duplication. A source of authority that charges localities to complete this management job is necessary. There must be a delegation and a source of authority. There must be a way of balancing the mandate of social service law with the mandate of family court law, with the mandates of education law to the best interests of a child in a manner that fits a particular community.

Children spend six hours per day in the school. There is a potential role of the school as a base for service integration though not as the sole agent or sole authority. Services need to go to children and not set undue demands on mobility or parental motivation.

Mental health services must be core to the design and the goal of providing services to the needs of the child and the family, not service to the needs of the system. No county government could embark on a course of integration because of the risk of violating

Federal and state mandates of categorical care and the risk of loss of revenue under the current system. These obstacles must be removed and incentives and sanctions put in place to force the integration and coordination of public resources to the child.

The precedent model exists in the community support services. The Federal Government provided the initiative for the design and facilitated the development of comprehensive systems of care for the chronically mentally ill through the Community Support System Program of the late 1970's.

The principles of the Community Support System Program recognized the need for social, residential, and mental health services to the chronically mentally ill while identifying strategies for financing that crossed barriers and boundaries. The potential role of the Federal Government in such a manner for children's services holds great promise.

The development of necessary elements of care as predicated on the availability of adequate numbers of appropriately trained professionals necessary to operate programs and provide care—again, I echo many of the testimonies you have heard this morning. The Federal Government has traditionally taken leadership roles in training. The necessity for responding to the need for child mental health professionals lends great urgency for a strong, innovative Federal effort in this area.

The last topic I would like to speak to is the financing of mental health services for children. The reimbursement mechanisms for child mental health services are derived from the adult service parameters. Whereas adults may be expected to be responsible for managing their access to health care across boundaries, it is clear that children cannot be expected to operate at that level of mobility and independence. A child in a dysfunctional family or a child with multiple problems needs case management and advocacy to obtain services and make sure those services work towards common goals.

A higher proportion of case management is required to serve children, and these services, as we have mentioned earlier, are not reimbursed from third party sources. The degree to which children require these services requires child mental health clinicians to serve fewer children per day, again reducing potential levels of revenue.

Appropriate care to children may necessitate individual sessions and family sessions and other services on the same day. Reimbursement policies generally only support one bill per day. These are serious financial disincentives currently in place that make good service to children not financially viable or attractive for mental health treatment agencies.

The degree to which mental health services to children are based on parental motivation and understanding of the relative value of treatment is another barrier to children receiving mental health services. When insurance coverage for mental health treatment is nonexistent or lapses before care is completed, the parent faces a dilemma in deciding how to allocate family resources.

The large number of funding streams available to support mental health services to children across the education, social services, family court, and mental health sectors must be carefully reviewed and analyzed to identify the degree to which the level of funds available is the constraint or the degree to which these methodologies of financing create barriers to service. The greatest benefit probably comes from a pooling of resources, but there are also new discrete funds needed for services to seriously mentally ill children.

In summary, there is much work ahead for policy-makers and administrators to address the convoluted and complex responses we have put in place over the last decade on behalf of helping our children. The work will require all of us to approach the mental health problems of children with creativity and flexibility. System boundaries must be permeable; mandates and requirements must be developed that protect children, not bureaucracies; financing must be available at levels to support needed services; and professionals must not specialize such that children are left in no-man's-zones unable to be assisted by the collective public agencies.

Thank you.

[Prepared statement of Judith Abbott Shanley follows:]

PREPARED STATEMENT OF JUDITH ABBOTT SHANLEY, ASSISTANT COMMISSIONER, ERIE COUNTY DEPARTMENT OF MENTAL HEALTH, BUFFALO, NY

My name is Judith Abbott Shanley. I am the Assistant Commissioner of the Erie County Department of Mental Health. The Erie County Department of Mental Health is the local governmental unit responsible for the provision of mental health services to the citizens of Buffalo and Erie County which is the second largest metropolitan area in New York State. I have held this position for five years, and have for ten years been involved in a variety of roles in relationship to the administration of child mental health services in Erie County.

The focus of my testimony will be the planning, organization and financing of children's services by the local governmental unit in the State of New York.

In the planning of children's mental health services the traditional 'estimate of need' figures employed are: 11% of children will be in need of mental health services in any given year, and 2 - 3% of children will be seriously mentally ill. In Erie County, there are 275,000 adolescents and children, 18 years of age of less in a population of about one million people. Using established need estimates, some 28,000 children are in need of mental health services annually. In 1986, 6,000 children were served. The proportion of unmet need is significantly higher for children needing mental health services than it is for adults. The prevalent rationalization for the failure of the mental health system to meet estimated need is the level of service availability through other auspices such as Department of Social Services, Division for Youth, Education, and Family Court.

Mental health planners must be more exact in defining the numbers and kinds of children in specific need of psychiatric services.

Children's services as a component of the mental health service system in Erie County currently has a waiting list of some 600 children for outpatient mental health services. A period of one to two months on a waiting list before entrance to service is to be expected. Whereas several years ago the predominant source of referral for mental health services came from schools and pediatricians, today the most frequent sources of referral are the Department of Social Services and the court system. There is no acute care psychiatric inpatient unit for children in Erie County. The long-term unit operated by the state serves eight Western New York counties, has a certified capacity of 56 and has had an average census closer to 75 for most of this year.

The lack of sufficient capacity in outpatient programs results in the children on waiting lists deteriorating between the time of referral and the time of admission to care. The lack of inpatient capacity results in the admission of seriously mentally ill children to pediatric units or to adult psychiatric units, neither of which are a suitable treatment environment for children. Recent data implicates a two-fold increase between 1986 - 1987 in the number of children under 18 who present for psychiatric admission in the emergency room of the county hospital (from 157 in 1986 to 164 in the first six months of 1987). This extraordinary increase in demand for the highest level of care for children is neither well anticipated or well understood in County Hall. The degree of alarm felt is caused only by the degree of frustration at the incapacity to conduct real analysis and achieve real understanding of what is going on.

We can only guess at some system issues causing this new wave of children seeking hospitalization and the real clinical psychiatric needs of these children.

The last decade has seen a significant thrust in social policy based on the premise that children should remain in their natural settings -- both school and home. One of the impacts of the Child Welfare Reform Act in Erie County is a 30% reduction in foster care placements. The children being placed are more severely disabled and are more apt to require institutional care rather than residential care. The preventive programs intend to prevent foster care placement, not primary prevention of mental illness. The resultant focus on open and founded cases often seriously curtails a child's continued care in mental health programs. The entrance of PINS Diversion, the family court placement of children in need of supervision, has resulted in a real press away from taking kids out of their homes and away from their families, with the expectation that mental health services can impact on the problems of these children and their dysfunctional families. This program in New York State did not for its first three years require the involvement of mental health in the development of local PINS Diversion plans. The mental retardation/developmental disabilities system has also tightened the admission criteria to its system, again removing a previous resource for children in need of service. A particular problem in Erie County which resulted from the transfer of New York City juveniles into Erie County Division for Youth facilities has reduced even further the number and range of potential placement options for children. These policy changes in other areas of the children's service sector were not planned in cooperation with the mental health sector such that it could be prepared for the kinds of children and their unique needs much less have in place the needed treatment options for children. This must be coupled with the increasingly sophisticated citizen demand for due process and full substantiation of allegations in the legal process in order for Family Court, Probation, Department of Social Services, or school systems to complete a formal determination. All of this leads to an increasing demand on the mental health system which has no mandated criteria for who should be served.

The profile of these children shows that they are younger, more violent, more disturbed, have more serious and multiple problems, are more likely to be suicidal, more likely to be involved with alcohol and drugs, and are more likely to come from single parent families. While single parent families constitute 24% of the family units in Erie County today, they represent 70% of the petitioners to Family Court in 1986. These children and their families are more likely to need more intensive clinical services and need to be served by several agencies at one time. This demands more coordination of services. Children and their families are more likely to miss appointments, not engage in the treatment plan regimen, and are more likely to drop out of care. If they drop out of care they are more likely to surface again shortly in either the same sector or another sector of the children's service world.

The uncoordinated involvement of these multiple sectors in providing service to children must be considered a principal cause of the ineffective, discontinuous, unresponsive care to the children and is anathema to the meaning of 'system'. At the direct care level, the various sectors (the public institutions of mental health, education, social services, and Family Court) operate in such independence and isolation from each other that nobody, not the psychiatrist or the social worker, nor the teacher, nor the probation officer, and least of all the poor parent can put it together in a way which brings the extraordinary public resources to bear on the whole child and his/her problems.

The expected outcome of the human service institutions -- what they consider success -- can be different depending on which sector the child entered. Where the Department of Social Services wants to prevent placement and close an abuse or sexual assault case, mental health wants to keep that case open to work with the child to assure resolution of interpersonal issues to maximize probabilities that development into an adult able to relate to others will occur. Whereas Probation is focused on dismissing a petition by parents to remove children from the home, mental health is focused on identifying and addressing the family dynamics that lead parents to a degree of powerlessness that court action was the only resources parents saw to impact on a dysfunctional situation. In the area of greatest unmet need there is the greatest degree of administrative chaos and very significant expenditure of public dollars in the aggregate.

Currently, the duplicative expenditure on assessment alone can result in children being assessed by all of these different systems. There is no comprehensive, integrated method for assessment that looks holistically at the child as a single system that has social, familial, and education problems. The specialized sources of authority for the different children's services sectors make integration of service planning at an individual or systems level not possible in any real way. There is no management information system that tracks the highly troubled youth and families as they are processed through multiple sectors. The attention to the confidentiality issues and the desire to not have a child's record follow them into adulthood becomes a true barrier to continuity of care.

In Erie County we attempted to address this diversity of auspice by establishing the Erie County Child Mental Health Consortium made up of all the major stakeholders in services to children from the voluntary and governmental sectors of mental health, education, the courts, and social services. The Commissioner of Mental Health has specifically delegated a system-wide planning role to this body. The other auspices have not delegated similar planning authority and responsibility to the consortium hence the capacity to assure implementation of plans by all the service sectors has not been realized.

I have begun to introduce the next topic of my testimony, and that is the organization of children's mental health services. The capacity to pull together these disparate auspices on behalf of children rest with the personal capacities of skilled clinicians or particularly innovative government officials. There is no system design directed at the comprehensive needs of children and the modular elements of service that need to be brought in and out as an intervention process occurs. The failure to reconcile the competing concerns of the various sectors involved in children's services results in a level of fragmentation or duplication or unmet needs or unsuccessful outcomes that cannot even be measured as we try to observe the current way we do business.

There is a consensus in many parts of New York State and Erie County that the children's mental health system must design a comprehensive assessment tool and establish referral policies and practices to assure clear identification of needs and access to a full range of services required to address those needs. The use by children with mental health needs of the other than mental health sectors must be carefully integrated such that a management information system with a child tracking capacity is present. We suggest that a central entry point be used for children in the community needing mental health services as identified by Department of Social Services, Education, court systems, community agencies, and families.

The attempt to address children's mental health needs cannot occur in isolation or as a response to a new wave demand without integrating with the other children's sectors. The county departments of mental health, social services and division for youth are responsible for coordinating services across the 33 school districts within Erie County. Flexibility exists at the county level to organize and arrange services that are responsive to the unique needs of children and communities within Erie County while being consistent with state mandates.

It is possible at this local level to identify and propose resolution of the apparent conflicts, inconsistencies, gaps, and areas of duplication across the children's service sector. A source of authority that charges localities to complete this management job is necessary. There must be a way of balancing the mandate of social service law with the mandate of family court law with the mandates of education law to the best interest of a child in a manner that fits the services of a particular community. Children spend six hours per day in the school. There is a potential role of the school as a base for service integration, though not as the sole agent or sole authority. Services need to go to children and not set undue demands on mobility or parental motivation. Mental health services must be core to the design in the goal of providing service to the needs of the child and family, not service to the needs of the system. No county government could embark on a course of integration because of the risk of violating Federal and State mandates of categorical care and the risk of loss of revenue under the court system. These obstacles must be removed -- and incentives and sanctions put in place to force the integration and coordination of public resources to the child.

The precedent model exists in community support services. The Federal government provided the initiative for the design and facilitated the development of comprehensive systems of care for the chronically mentally ill through the community support system program of the late 1970's. The principles of the community support system program recognized the need for social, residential, and mental health services to the chronically mentally ill while identifying strategies for financing that cross various administrative and financing boundaries. The potential role of the federal government in such a manner for children's needs holds great promise.

The development of necessary elements of care is predicated on the availability of adequate numbers of appropriately trained professionals necessary to operate programs and provide care. We do not have professional training opportunities in each of the core disciplines critical to serving children. Most professional programs do not require specialty training and experience in serving children, and few disciplines other than medicine have special advanced requirements prior to allowing a clinician to serve children. Most professionals become child specialists on the basis of experience and the pursuit of continuing education opportunities by choice. This is true even in larger metropolitan areas like Buffalo with a large number of academic institutions. We do not have sufficient numbers of professionals to staff the programs we need. The Federal government has traditionally taken leadership roles in training. The necessity for responding to the need for child mental health professionals lends great urgency for a strong federal initiative in this area.

The last topic I would like to speak to is the financing of mental health services for children. The reimbursement mechanisms for child mental health services are derived from the adult service parameters. Whereas adults may be expected to be responsible for managing their access to health care services across boundaries, i.e., needing to see a mental health clinician for treatment of manic depressive illness, or vocational counselor for entrance into a training program, and a physician for a regular physical exam, a child cannot be expected to operate at that level of mobility and independence. A child in a dysfunctional family or a child with multiple problems needs case management and advocacy to obtain services and make sure those services work together towards common goals. The school teacher needs to know the treatment plan of the mental health professional and how it can be used to change the teachers patterns of responding to the child as treatment progresses. A higher proportion of case management is required to serve children. These services are not reimbursable from third party sources. The degree to which children require these services requires child mental health clinicians to serve fewer children per day, again reducing the potential levels of revenue. Appropriate care to children may necessitate an individual session and a family session on the same day. Reimbursement policies generally only support one bill per day. These are serious financial disincentives currently in place that make good service to children not financially viable or attractive for mental health treatment agencies. The degree to which mental health services to children are based on parental motivation and understanding of the relative value of treatment is another barrier to children receiving mental health services. When insurance coverage for mental health treatment is nonexistent or lapses before care is completed, the parent faces a dilemma in deciding how to allocate family resources.

The large number of funding streams available to support mental health services to children across the education, social services, family court, mental health sectors must be carefully reviewed and analyzed to identify the degree to which the level of funds available is the constraint to expanding mental health services to meet the needs of children, or the constraint is the methodologies of financing create barriers to service. The greatest benefit probably comes from a pooling of resources, but there are also new discrete funds needed for services to seriously mentally ill children.

In summary, there is much work ahead for policy makers and administrators to address the convoluted and complex responses we have put in place over the last decade on behalf of helping our children. The work will require all of us to approach the mental health problems of children with creativity and flexibility. System boundaries must be permeable, mandates and requirements must be developed that protect children not bureaucracies, financing must be available at levels to support needed services, and professionals must not specialize such that children are left in no man's zones, unable to be assisted by the collective public agencies.

Chairman MILLER. Thank you.

I was taken by the phrase at the end of your remarks there on the ability to address the convoluted and complex responses we have put in place. I get the sense after this morning that, in fact, that is probably an accurate description.

Is it fair—and I will start with you, Stuart—that you are describing to us not only the problems in terms of dealing with the numbers of people who are presenting themselves for treatment on their own volition or because somebody else has recommended it, but you are telling us you have a more difficult case load?

Mr. MCCULLOUGH. Yes, sir. We are seeing increasingly dysfunctional children capable of higher degrees of violence than was true two years ago, one year ago. There is a propensity towards violence, sexual, and other kinds of assaults.

Chairman MILLER. Let me ask you this. When you say you are seeing increasingly dysfunctional children with a greater propensity to violence, are you talking about the child being violent or the child coming to you out of a more violent situation or both?

Mr. MCCULLOUGH. Both, but I am specifically saying that the child himself or herself is more violent. There is less impulse control. They just flat out are capable of doing things to other children primarily, sometimes adults, that weren't common, were very unusual, two or three years ago, and are becoming frighteningly common.

Chairman MILLER. That is your time span? You are talking about a comparison of two or three years?

Mr. MCCULLOUGH. Two, three, four years.

Chairman MILLER. You are not talking a decade ago, you are seeing a change within a relatively short period of time.

Mr. MCCULLOUGH. The last 4 years, yes—48 months. The last two years, it has become acute for us.

Chairman MILLER. Now let me ask you. Are drugs a part of that, or are drugs laid on top of that, in the sense that you then have children who are also more violent, in more violent situations, who are then either drug users or the victims, if you will, if their parents are using drugs? Are the things one and the same, or do they show up in combination?

Mr. MCCULLOUGH. The environment that they live in is—count alcohol and drugs, count prescription drugs. and you have just a phenomenon of drugs out there—alcohol, prescription drugs, street drugs. I don't think the violence is caused by drugs, I think it is just another exacerbating factor.

Ms. SHANLEY. May I add something?

Chairman MILLER. Just a second.

You are the county hospital.

Mr. MCCULLOUGH. Yes, sir.

Chairman MILLER. What about when you compare that, the clients, if you will, of what were described earlier as the for-profit, intensive care, some of these psychiatric hospitals who sort of say, "If you have got a problem with Johnny, come down to"——

Mr. MCCULLOUGH. I've got to tell you, Congressman——

Chairman MILLER. Are we talking about families that manifest the same problems but at different economic levels?

Mr. McCULLOUGH. Different economic levels. This is not a poverty phenomenon. At one of the private hospitals that I think should remain nameless, there have been some extraordinary experiences in the last month with kids trying to get out of that hospital using very innovative, almost guerrilla fighting techniques for those kids to get out of there: fires in hallways, opening doors, and the like. That is a program only for families that can afford private insurance. So this is a phenomenon for both poor and upper middle class, and middle class as well. This is not a phenomenon restricted to the poor. Certainly it is true for the poor but not just poor.

Chairman MILLER. Let me ask you this. A number of you testified to the notion that you are seeing children of single-parent families. If a distinction can be made, is that because of the increased number of single-parent families that you are seeing, or is it conceivable that—what do I want to say?—the increased stress that perhaps single-parent families now find themselves under that might be different now as opposed to a number of years ago; or is there a way to tell?

Mr. McCULLOUGH. One of the things that I think it is really important for all of us to remember is that the extended family no longer is nearly as active in raising the child as it used to be. The aunts, and uncles, and grandparents who used to coach us on how to be parents very typically are not there any more, and they are not there to support us when we get tired. If you really exacerbate that by being a single-parent family and you are working a full-time job, sometimes a 10-hour-a-day job, you come home and you are really very, very, very tired. The help that we used to get when we were part of an extended family isn't there these days, and it is really making things extremely difficult for folks.

Chairman MILLER. Anybody else?

Mr. FELTMAN. A couple of points. One, in California, like a lot of other states in the nation, the cost of necessities has increased dramatically over the last five years, particularly the cost of housing. And the people that are functioning at the marginal economic levels, such as single parents, are faced with a degree of pressure to provide essentials that provides a kind of relentless day-to-day pressure that manifests itself frequently in the lack of supervision of their children, short-temperedness, intolerance, and inadequacy in terms of their ability to cope when problems get presented to them by the school or by a local policeman with their child.

Chairman MILLER. Mr. Davis, is there something comparable going on in a rural area like the one you serve? Are you seeing a change in family stress or the types of clients that you are receiving?

Mr. DAVIS. No. People from rural areas are not exempt from any of the basic stresses that families experience everywhere, including urban areas, stresses including marital problems, separation of parents, loss of a parent through death, the single parent. All of these problems are prevalent throughout our society, they are not limited just to urban areas.

Chairman MILLER. Would it be reasonable to draw a conclusion that this phenomenon you are talking about is across the national landscape? It is not a question of economic position, and apparently it is not so much a question of geography. The numbers, obviously, are different, but the phenomenon is recognized in each one of your settings. Is that accurate?

Ms. SHANLEY. The degree to which they show up in the mental health system appears to be one of the things that is increasing. As foster care has become a less available option, as Division for Youth has had different ways of doing detention, there is more and more a sense that when all else fails we will see if the mental health system can help us.

You talk to the psychiatric facilities, and they say they are getting a child now that they would never have had before, and they are not sure that they are truly psychiatrically ill in the degree to which current methodologies can help them intervene.

There is some concern that you are dealing with——

Chairman MILLER. That is a mouthful. What are you telling me?

Ms. SHANLEY. There are so many more conduct disorders that are ending up as admissions to psychiatric centers, at least in Erie County, and in need of admission, that may have been previously dealt with through traditional juvenile or justice kinds of systems.

Mr. MCCULLOUGH. Conduct disorders, the parents just flat out can't handle them. If they have private insurance, they are ending up in private hospitals. We are talking about building bonfires, throwing them out in the hallways, setting off the fire alarms, having the doors opened, and splitting. We are talking guerrilla warfare to get out of these institutions.

These are not psychotic kids that are having significant mental disturbance sufficient not to know where they are in time and space or that kind of thing; they are conduct disorders, but they are well-to-do. The poor folks are ending up in our juvenile facilities. These folks are ending up in private institutions. You have heard that today, and I have read in your previous testimony from other hearings that this phenomenon is occurring across the country.

Chairman MILLER. I am going to stay through the vote, so let me go ahead and let other Members ask questions.

Mr. Holloway.

Mr. HOLLOWAY. We have described before us already what is a typical mentally ill child. What type family does this child come from? What is a typical family of a mentally ill child?

Mr. L'HOMME. I would just like to respond to both of your questions, if I could. To start off, City Lights has dealt with children who are not from families at all but have been in many, many foster families. What we are finding is a reluctance on the part of the mental health system to deal with those kids who are conduct disordered, who are violent, who are lighting fires, and they are showing up not in mental health but they are showing up in the juvenile justice system. We have more and more referrals from kids from the Superior Court, from PINS, from any number of different places.

When we look at foster families and we keep saying return the kids to their natural family, return the kids to their natural family. Let me just say one little piece that is different. Some long-term foster care in our research has found that those kids are actually functioning at a higher plane than the kids who have stayed in families. The kids that have remained in families in the District of Columbia, they are families that are so dysfunctional I couldn't begin to describe them.

Chairman MILLER. You are getting kids at the end of the process. I think Mr. Holloway is asking, when we start to get referrals from families, what are we looking at in terms of the profile of the family?

Mr. L'HOMME. I am sure that somebody else is going to respond to that, but one of the things we are finding is that the families are as disturbed and as delinquent as the children that we are getting into our programs.

Mr. HOLLOWAY. Are they from single-parent families?

Mr. L'HOMME. Considering the demographics of the District of Columbia, they are overwhelmingly single parents.

We look at natural family as far as the grandparents, their aunts, and their uncles, and there are those kids who attempt to stay within the community, and just because they are so out of control—a kid that I referred to in the beginning of my testimony, a kid who just was out of control, was sent to a residential treatment center in Texas, with no psychotic behavior whatsoever besides being out of control.

Mr. HOLLOWAY. Are yours very similar to that?

Mr. L'HOMME. Our kids are very, very similar to that, over and over again.

Mr. HOLLOWAY. But I am speaking from a rural standpoint much like Louisiana or any other rural society.

Mr. L'HOMME. Oh, I'm sorry.

Mr. HOLLOWAY. Are most of the problem children coming from single-parent families?

Mr. DAVIS. Two-thirds of the children in our case load are not living with both biological parents. Now in some cases there is a stepparent involved, but two-thirds are in that category.

Ms. MENNIS. The Philadelphia Child Guidance Clinic serves a range of kids in terms of financial resources, poverty, and privately insured and publicly paid, and I'm not sure that there is a typical family and a typically mentally ill child. The kinds of changes that I am seeing are increases in a range of kinds of kids.

We are seeing more psychotic or prepsychotic kids, who will be your chronically mentally ill young adults. We are seeing more suicidal kids. We are seeing more child abuse kids. We are seeing more kids who need placement. Their families really range also. There is certainly a preponderance of single-parent families, but you have ordinary families, who ordinarily function quite well, who are under an enormous amount of stress from a kid who is out of control; and you have very dysfunctional families who are under the enormous environmental stresses of poverty, lack of employment, poor housing, and a variety of other things, who are perhaps less able to cope.

But I really think that you can't say there is a typical family, that a mentally ill child lives in this kind of family.

Mr. HOLLOWAY. I agree with you, but still we gave an illustration of a typical child, and I think there is a higher percentage of children who are going to come from a single parent.

Continuing that a little further, of the ones that come from families with two parents, both living, is there any comparison with families where mothers work in the family versus—I know there are all types and you are going to have every kind, but there has got to be more of one type. Are there more of the children coming from where both parents work?

Mr. McCullough. I don't have any indication that that is true, no. We are seeing no typical profile family, no socio-economic, racial, geographic family. What they do all have in common, I can't stress too strongly to you, or a high percentage of them have in common, is a lot of substances that exacerbate the already severe communication problems.

If people are having problems communicating well at the adult level as parents and they are drinking a lot or doing a lot of drugs, their chances of improving that communication are significantly decreased. That doesn't make any difference whether you are a single-parent family, both parents working, or you have dad staying home while mom works. It really doesn't seem to matter.

Mr. Holloway. Mr. Davis, of course, being from my area, is probably one of the few witnesses we have from really what we would call a rural area. I realize Rapides Parish is probably 125,000 people, but all the area around us is parishes made up of 8,000 to probably 40,000 people.

You mentioned in your testimony that for two years you have designated a doctor to go out one day a week out to some of the rural parishes. Are you still doing that? number one, and what has been the effect of that program of going into these rural parishes? I think you might have even mentioned Concordia or some of the other parishes that you have gone to.

Mr. Davis. Yes, we do send one worker one day per week to cover three parishes that are separated from us by poor roads and a pretty large expanse of water. It has made services more accessible to those people. However, we are not able to provide a full range of services to those people in that area with such limited resources.

Mr. Holloway. Do you notice a difference in the children in the rural area versus the city area—well, I would even say in the community mind. I grew up as rural as you can grow up. Do you notice a difference? I know what happens where a child is almost an outcast, whereas in the city you can kind of get lost back into the numbers, but when you are in a rural area you have pretty well got a star over your head that says, "This kid has got mental problems, and we don't want anything to do with him." I think maybe that has a lot to do with them coming forward to seek treatment. Do you notice problems along that line?

Mr. Davis. I think in many ways the stigma is greater. Because everyone knows everyone else's business, people are less likely to want to be identified as having a child with emotional problems. Often, that results in a delay of referral to the clinic for services.

Mr. Holloway. I think a lot of times we forget about the rural areas of country and everything is aimed toward the large cities where the bulk of the population is. My personal feeling is—and I would like to hear from you—there has to be more of a need in the rural areas for, I think, all services, not only for mental but all services, that we have really forgotten about, and that is where unemployment is going to be high. Many of the problems we have come from the rural areas, and they are problems that are going to be harder to conquer. Do you have any comment along that line?

Mr. DAVIS. Yes. I think it is just important that we not forget that there are troubled children out there, that they do have many of the same problems as urban children.

Also, there are some unique problems of children in rural areas. Children and adolescents have less group recreational opportunities. There are fewer opportunities for peer relationships. We have some parents who say they live at the end of the road, the child has no friends, there are no opportunities for peer relationships.

Parents, while they may have an extended family, sometimes live in isolation when it comes to having to bear the burden of the problems of their children alone.

Mr. HOLLOWAY. I am going to run vote, so I appreciate it.

Thank you, Mr. Chairman.

Thank you.

The CHAIRMAN. Congressman Skaggs.

Mr. SKAGGS. Thank you, Mr. Chairman. I have to leave for a vote in just a minute as well, so I'll be very brief.

I wanted to ask you all, and I know you are in the program side rather than perhaps the clinical diagnostic side, but do you see any potential for us making some improvements as to the young part of the population that is diagnosed as mentally ill in better screening to weed out misdiagnosis?

I am familiar with some of the work that has been going on, particularly in looking at nutritional and other biochemical bases for misdiagnosis. It would seem to me that, particularly in the poverty portions of your client populations, the potential for nutritional connections with early childhood emotional and mental disturbances is great and that that might be a potential area for intervention on causative levels that could be done much more efficiently than waiting for symptoms to emerge that can be classified as mental illness or emotional disorders.

Mr. FELTMAN. I think there is a very important role in the public sector for a child psychiatrist, for medical doctors, as part of a multi-disciplinary team, and from what I understand, across the country we are seeing fewer and fewer psychiatrists available as part of these public agency teams; the training in medical school is increasingly aimed at those who can afford private psychiatric treatment on an outpatient level. These programs we are talking about don't include much participation of psychiatrists, and we are vulnerable in the area you are talking about because we don't necessarily have the degree of medical expertise to screen the child that we would have if we were turning out more child psychiatrists that had an interest in working in the public sector.

Ms. MENNIS. I would agree with the gentleman's comments about the serious shortage of child psychiatrists in the country and certainly in the public sector, but I would also add that if there is any error on the diagnostic side it is probably on the error of underdiagnosis rather than over-diagnosis. Mental health clinicians, including psychiatrists, tend not to want to stigmatize a child with a very serious label that they will carry with them for the rest of their lives, and I think that is why you see significant numbers of adjustment reaction diagnoses in the child psychiatric system.

Mr. SKAGGS. I wasn't necessarily saying over or under but mis, which I don't think carries the same implication that once behavior has gotten to the point where people are looking at that explanation, at least with the adult population, sometimes the medical explanations in a traditional sense are not looked at. I wonder whether you are also suggesting that we need pediatricians that have more training on what may or may not be, in fact, psychiatric conditions as well as more psychiatrists that are specializing on the child's side.

Ms. SHANLEY. It gets even more complex when you begin to look at adolescents, and adolescent health care is not really well carried out.

In Erie County, in a recent study that was done on alcohol use, it suggested that 24 percent of 15- and 16-year-olds are considered moderate and heavy drinkers. How many of the pediatricians that they go to, if they go, when they started talking about some level of anxiety or some level of depression, would automatically think to ask, "When did you have your last drink?" You really have a lack of overlap between the pediatric and the adult world for a major segment of our population, which is where they first begin to have problems.

You also have to remember that children and the diagnosis of children, even from a pediatrician's viewpoint, is the most difficult area for differential diagnosis.

Chairman MILLER. Let me interrupt. You are going to miss a vote.

Mr. SKAGGS. Forgive me for having to cut out. Thanks.

Chairman MILLER. Stuart, you were shaking your head on the point that Ms. Shanley made on this alcoholism.

Mr. MCCULLOUGH. I think one of the questions we might ask is, how many mental health workers would ask, "When was the last time you had a drink?" The awareness of that phenomenon is only slowly beginning to dawn on us.

You have to remember that our business is one of waking up slowly to things. Six or seven years ago, we had no idea that we were seeing nearly as many sexually abused kids as we were seeing, and we just didn't see it. Three years ago, we weren't asking too many questions about alcohol and drug abuse. So we are really the blind men around the various ends of the elephant slowly piecing together a mosaic of what it is we are actually looking at as we become more sophisticated.

Chairman MILLER. There is a story in our local newspaper where you are quoted, or you are looking at a study that was done in 1983, where you are indicating that 82 percent of the patients that you referred to the State hospital had alcohol and drug-related problems.

Mr. MCCULLOUGH. That is right.

Chairman MILLER. So what you are saying is that you have got to back all this up a little bit.

Mr. MCCULLOUGH. Back it up a little bit.

When we took a look at that, it shocked us. In not one of those charts had we addressed that problem from a clinical standpoint.

We were talking about all kinds of psychiatric symptomatology; we weren't talking about substance abuse at all. When we looked into it, we found that there is very little training.

We were talking earlier about universities, and no one could particularly name to you a good university for training good children's clinicians, especially around the areas of being comprehensive around case management and other kinds of more community-based treatment.

Well, there are no universities, to our knowledge, anywhere that are training people—there is no unified theory anywhere—about how to treat people that are substance abusers and also providing severe mental disturbances as symptoms. So we have a long way to go before we can even begin to provide our staffs or ourselves high quality training, because we are going to have to create it ourselves. Right now, unless other members of the panel are aware of any, I don't know any good training going on anywhere in the country.

Chairman MILLER. How did Ventura make sense of all of this?

Mr. FELTMAN. I think we were very fortunate in having some political muscle at the top that made this a priority and said we are going to accept some responsibility for some public sector children that exist already, and that was a county supervisor and a judge who teamed up and basically cracked heads with these agencies that were independent.

Chairman MILLER. What did the judge use for enforcement?

Mr. FELTMAN. Really, face-to-face kinds of pressures. A lot of these turf issues dissolve when people are talking across a table about a particular youngster or policy development at a local level. The problems are much more apparent when they are dealt with anonymously by telephone or through some memo by people who don't know each other and don't feel any kind of personal pressure to work out a rational and responsible approach.

If the judge, who is seen as an authority, and a county supervisor, who is seen as an authority, says, "We will have one set of programs for Ventura County children, not mental health programs, social service programs, juvenile justice programs, and education programs; we are going to target these kids most at risk, and you just do what you do well for those children, that is your responsibility," then you have a whole theme going forward.

We have written interagency agreements that are absolutely essential to the development of definitions between what we do versus what other people are expected to do in the area of treating children that have multiple problems.

I think that was the beginning of it, and many of us, as are many of the people here and witnesses in the previous panel, are very interested in developing a system of care, because they know that is more effective, and they know that children have multiple problems. If we can just get the ball rolling, then I think the tide, the pressure, would sweep those residuals or vestiges of turfdom that exist at agencies particularly and say, "Well, I just do this over here."

Chairman MILLER. Congressman Hastert.

Mr. HASTERT. Thank you, Mr. Chairman.

I have been interested especially, Mr. McCullough, in your testimony where you talk about creating almost community mores, cultural values, as something that has to be done. You also talk about local leadership. I agree; I think you are right on target. The question is how you do that and, once you do that, how you focus and harness that leadership. What is your insight? How is this being done, or is it?

Mr. McCullough. I think all of us can safely tell you that increasingly we have citizens—we are all bureaucrats, at least I think we are all bureaucrats, here—citizens on us pretty strongly saying, "We want you to organize better."

I think we have to begin to see ourselves as what I call social engineers. We are really in the business of getting folks organized to work collaboratively and collegially and cooperatively, and it means listening to those citizens, it means getting them involved, it means taking their criticisms not personally but listening to them and applying them and harnessing their energy in a focused way.

People are willing to put in an amazing amount of work if you are, but you have got to listen to them, and you have to share power, share control, both. The way that you are providing services may not go the way it would go if you were traditionally making a decision with just a few of your staff. In fact, things are going to be different than you probably even could imagine they were going to be, and you have got to be willing to go with that and see what develops.

We are talking a quantum step. Typically, when you take a quantum step, you are stepping into an area that you know initially you can't control and you are going to have to grow up to. That is a career phenomenon.

Mr. Hastert. So actually you are saying a change in this area, if there is going to be change, has to start from the ground up.

Mr. McCullough. Absolutely.

Mr. Hastert. How about funding? Do you find as more people get involved there is a greater acceptance to put resources in these types of programs?

Mr. McCullough. I think it is cyclical, and I think we are at the low end of the trough right now. I think as more citizens get involved we will begin to see more funding.

In "Megatrends," Nesbitt talks about more and more local control, networking, neighborhood groups. I think folks want more and more local control about specifically where their dollars go. We have a massive transportation problem in Contra Costa County, and the citizens voted down local dollars to change that and improve it because they are mad about the developers making money and the people not making money having to put up with the traffic. When I go to them and say, "I want you to fund a children's mental health system very early for little, tiny kids, to get to them very young and to the families very young," I think they are going to vote for it, and I am either dreaming or I'm right, and we will find out.

Ms. Mennis. I would like to comment on the funding question. I think the changes need to occur from bottom up as well as top down. People at the top, people at the level of county authorities have to begin to recognize problems that exist in children's services. They also have to be able to look at money in a different kind of way.

The Medicaid system does nothing but provide disincentives to providing services to children. There are disincentives at the level of hospitalization because they don't pay enough to cover the costs of services; there are disincentives at the level of outpatient treatment because they don't pay enough to cover the costs, and they place a lot of limits on the way you do those services; you can only do *x* number of services a day or month; you can't see the kid in the home; you can't see the kid in the school; you can't get paid to see the foster family or the child welfare worker.

In order to get around those kinds of constraints, you sometimes have to forego some Medicaid money—which is a real problem for a State, which is matching State money with Federal money—and reallocate resources locally. That is, in fact, what happened in the development of the Social Rehab Program that I described earlier. We took a chunk of outpatient money, added a little more money, and the county added a significant amount more money to that and said, "Don't worry about the Medicaid money. The families and these children need a different kind of service."

So you have to be able to look at it differently, and the Medicaid system needs to begin to change, I think, to respond to the needs of the kids that are out there needing services.

Mr. HASTERT. So are you saying that, as somebody else mentioned before, the service provision facilities out there track adults, and actually children are a different entity in themselves?

Ms. MENNIS. Well, you know, both the service system and the funding of the service system reflect, I think, an earlier model of the provision of services both at the adult and the child level. They were looking at a time when what you did was provide outpatient services and inpatient, so Medicaid funds outpatient and inpatient. We are looking at a different kind of kid with more longer-term needs, with more disorganization in their lives, and with more service intensity needs, and Medicaid doesn't pay for that and the service system isn't organized around that.

Mr. HASTERT. Mr. Feltman, you brought up an interesting aspect here, and I think I understand what part of the problem is. Where I come from, we really have a strong county system, we have a State system that delivers services from the top down, or tries to deliver those services from the top down. I think they make a good effort.

Anyway, you talked about Public Law 94-142. Where I came from, it seemed like that was almost for a select group of people in society; that was a good way to send their children off and not ever see that problem again. It took a lot of resources away from the pot both on the local level and certainly in the State area. Would you make any recommendations in that area?

Mr. FELTMAN. Well, in the area of local mental health services, I am very supportive of Public Law 94-142, and I believe that these children, as all children, have a right to a free and appropriate education and that this is, in fact, identified as a handicap.

The problem has occurred because education sees itself as providing education services, not mental health treatment, and here they have a seriously emotionally disturbed kid, which they in fact label seriously emotionally disturbed, and they provide an educational program devoid of mental health treatment.

Now what we have said is that public mental health dollars should first go to the priorities that are mandated under law. This is Federal law for handicapped children. Public mental health has the responsibility to provide treatment, not education. So mental health ought to deliver the treatment that is part of the individual education plan of a handicapped youngster in public school and, in that way, form a partnership between public schools and mental health.

We have the schools supporting mental health services, because we have said that we will use our money to facilitate the proper education of your handicapped kid so they don't end up going into residential nonpublic schools because the public schools have to acknowledge they can't serve them and then pay the bill to send them off to no man's land. That is bad for the kid, and it costs a fortune.

Mr. HASTERT. That is exactly the point. We found, and a lot of our schools are saying, maybe there is a way to purge ourselves of these problems. In the Midwest, we have sent kids all over the country. Texas is another area that you talk of. The New England schools that we have sent kids out to. I am talking about millions, and millions, and millions of public dollars being spent for a very small number of kids, where those dollars probably could be spent much better, with a better return across the board, if we start to set up those services on the local level. Yes.

Mr. L'HOMME. I don't think it is entirely true that mental health has not been in public education. There have been models that have been in existence for nearly 20 years. Both the Rose School in psycho-education and the re-ed models that are in North Carolina and in Tennessee have been doing exactly that: bringing the mental health professionals and teachers together to work in a collaborative effort to keep kids out of institutions and in the community. City Lights is definitely an outgrowth of those kinds of programs that have been in existence for a long time. The only trouble is that those programs are very, very small. They deal with very few kids, and there is a law of diminishing returns.

Chairman MILLER. But I think the model is more along the lines Mr. Hastert is talking about, where schools are very nervous about making this kind of commitment, because they are very concerned that they are going to end up spending what they view as their educational dollars on placement of those children in specialized educational facilities to deal with those problems. At least in our area, there seems to be a real nervousness.

I agree with you, there are models to do it another way and to prevent those dollars from being spent in that intensive fashion, but I don't see many school officials coming forward and saying let's develop this model together. They would rather not label that child, they would rather not place that child, they would just as soon not even see that child come through the front door of the school. But for the attorneys in most instances, I don't think you see school districts responding voluntarily to that one.

I understand the problem, I understand the finite dollars that every one of these competing institutions is working with, but I think the model you are talking about is really an exception as we scan the landscape.

Mr. L'HOMME. I think you are absolutely right, but I also think that we do have a direction to go in. We know what to do, and how do we go about doing it? Even beyond regular education, there is a guy at Harvard University Graduate School of Education, Perry Landon, who says to move the mental health centers into the schools. That is where the kids are at the beginning. It is just not mental health and birth control, it is health for our children.

Chairman MILLER. That is what Richard Lugar said 20 years ago.

Mr. HASTERT. In your statement though, you said that even your problems are becoming much more intense year after year and the returns are diminishing. Is that not correct?

Mr. L'HOMME. It is diminishing returns even after you establish a program with as little as 30 children in it. You keep adding, and it becomes overwhelmed, and you do less instead of more.

Mr. HASTERT. One thing I think underlies the whole issue, and I think you have brought it up time and time again. Really, to solve the problem, it takes a core of dedicated people, those people who are willing to take special types of foster children into their homes and take the time and the intense emotional strength that goes with it. There are not many people like that.

Mr. L'HOMME. That is right.

Mr. HASTERT. To develop those resources and reinforce those people back in the local level, to keep those kids in the local setting, is really the objective.

Mr. MCCULLOUGH. If I could just quickly say, in AB-3632 implementing Public Law 94-142 in California, what we are finding across the State is that our poor school districts have been very loath to respond. Our more affluent school districts have been a little quicker to respond. The parents have gotten in touch with advocates, and they recognize that they cannot be billed, no matter what, for these services.

So in Contra Costa County, we have our most affluent folks using this bill. We have $35,000/$40,000 automobiles tooling up to our outpatient clinics for an hour of outpatient free therapy in our clinics, because they are coming through this Public Law 94-142 avenue, and in our poor school districts we have got like eight referrals from the whole place.

So there is a game being played here where the folks that are poor are being very cautious and the folks that are a little better educated and a little more aggressive are really taking advantage of this, and it really disconcerts us.

Mr. HASTERT. It was to my dismay through the appropriation process in finding out that we had a cadre of very fine attorneys. They were whipping up this clientele in certain areas of our State, and it was the "thing to do." That is frustrating, to see how those dollars are spent and where the allocations go.

Ms. SHANLEY. In Erie County, for the city of Buffalo, which is not an affluent city, we have some 60 children on home-based instruction because they are too emotionally disturbed to be in the classroom. That is untenable. So I am not sure where the options are in this, but we must do something.

Mr. HASTERT. Thank you very much.

Thank you, Mr. Chairman.

Chairman MILLER. If I can put a positive spin on this hearing, I think for us as policymakers as we look at this, from City Lights which deals—if your description of your caseload is correct—with a lot of kids that spent a lot of time in the system before you saw them, and to Ventura, that is trying to develop the model from the time of first encounter throughout that system and everything in between.

I think what you are telling us this morning is, in this population that most adults consider the most difficult, the adolescents or children with emotional problems, there is a whole series of models out there that can dramatically reverse the manner in which we spend money.

Not to suggest that you can solve the whole problem by stretching the dollars, but clearly, examples that we have been given here this morning suggest that by rethinking how we are expending those dollars, by coordinating how we expend those dollars, and by providing comprehensive services, we can serve a greater number of children. We can also apparently have better results if one of the goals is at least to try to keep those children that need not be in state hospitals out of state hospitals.

Also, it appears that if we are willing to recognize some of the related problems—alcoholism, drug abuse—in the family and in the client, that we also have some potential for changing the methods of treatment. I have got to say that so I don't go out and commit suicide after I go to these hearings. Now I feel better.

This has been very helpful. The concern I have is for us to start to see—and we are going to need your help in the sense that you are on the line of delivering these services—where is it that we can make some changes at the Federal level or encourage changes at the state level to facilitate these models.

The thing that interests me about Ventura is, in the five years of this committee, in most of the areas where I see comprehensive change, whether it is in adoption, foster care, or mental health services, I usually find some Superior Court judge or municipal court judge—whatever the system is—who gets fed up with the system, like Public Law 94-142 in Louisiana, and says, "Wait a minute. This is the law, and we are going to enforce it, and now the political body is going to have to respond to it," which brings about some of these changes.

But even if you do that, the descriptions of Medicaid barriers, of funding and reimbursement barriers, of insurance barriers, I think, warrant an examination certainly by the Congress to see, if we are not going to have a lot of new dollars to appropriate, that we have some ability to facilitate these effective models and what appear to be more efficient models. So we will probably be getting back to you on that one, because I think we clearly need some help. What we need, I think, is a greater understanding of where those bottlenecks exist and where maybe small changes at the Federal level can have fairly big returns at the local level, the key people.

It is a theme here where we constantly pound on the dais and say we want coordination, and cooperation, and interagency action, and then we find out that in many instances it is the Federal law that prevents some of that from taking place, because you are required to chase reimbursements in a complex and convoluted fashion.

Thank you for your help. I really mean it. This is not a subject which the committee intends to leave at one hearing. We appreciate all of your input and all of your help. Thank you.

[Whereupon, at 12:40 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT FOR THE HON. GEORGE C. WORTLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I commend you for holding this hearing on a very sensitive topic Children's Mental Health. The topic of mental health is very difficult for many to discuss. When a child is involved, it can become more difficult to face.

There are two areas of children's mental illness that are of concern to me. First, the labeling of children at a very young age. Sometimes children are misdiagnosed, but the label remains with them throughout grade school. Just because a child may have a difficult time adjusting to school does not mean that the child is emotionally disturbed. There could be some problems in the home that manifest themselves in other ways.

Another area of concern is that of institutions and restrictive settings. Countless studies have shown that most people with mental illnesses benefit from living in a less restrictive setting as opposed to an institution. Furthermore, the cost of living in a group home setting is about half of the cost of residence in the institution. These people deserve to be mainstreamed into society as much as possible and not sheltered and hidden away in a large antiseptic looking building.

I look forward to hearing the testimony of our expert witnesses today. I hope that they will be able to address some of my concerns and enlighten me in progress in these areas. Thank you.

PREPARED STATEMENT OF GARY B. MELTON, PH.D., PROFESSOR OF PSYCHOLOGY AND LAW AND DIRECTOR OF THE LAW/PSYCHOLOGY PROGRAM, UNIVERSITY OF NEBRASKA-LINCOLN

Mr. Chairman and Members of the Select Committee on Children, Youth, and Families:

As past president of the Division of Child, Youth, and Family Services of the American Psychological Association (APA) and chair of its Task Force on Economics and Regulation of Children's Services, I am pleased to present this statement on the subject of financing of child mental health services. Many of APA's 87,000 members are involved in scientific research or professional practice related to mental health. In particular, APA members have contributed much of what is known about the nature of child mental health problems, the efficacy of various means of preventing or treating such problems, and the systemic variables that affect delivery of services to children, youth, and families.

Unfortunately, precise statistics are generally unavailable to show the frequency of delivery of various forms of mental health services to children and youth and the sources of funds for such services. Partly as a result of a lack of reporting requirements for states receiving mental health, child health, and child welfare block grants (a situation that we hope Congress will remediate), the picture that is available of the child mental health system is incomplete. Many states cannot even identify the proportion of their public funds for mental health that is provided to children. With the rapid, largely unregulated rise of the for-profit sector in children's services, this picture is likely to become even fuzzier. Major problems exist in preserving accountability of programs serving children and youth.

Nonetheless, two general conclusions are clear. First, children's services are underfinanced. As psychologist Jane Knitzer graphically showed in her report for the Children's Defense Fund in 1982, states generally have not developed even the rudiments of a continuum of care. Some state departments of mental health do not have a single professional staff member whose primary job is to develop and supervise children's services. The situation has improved somewhat in the past five years because of initiatives in some states that were stimulated by the Child and Adolescent Service System Program (CASSP) in the National Institute of Mental Health and the children's "set-aside" in the Alcohol, Drug Abuse, and Mental Health Block Grant.[1] Still, mere examination of the proportion of mental health dollars that goes to state hospitals and other largely adult inpatient facilities shows clearly that children do not receive their fair share of expenditures for mental health services.

Second, the problem is not simply one of insufficient financing; the distribution of available resources is perverse. Providers are rewarded for providing services that are unnecessarily restrictive of children's liberty, destructive of family integrity, and unduly expensive. Indeed, the demonstrated efficacy of services and the financing available for them are inversely related. The result, unsurprisingly, is that the forms of service that have the best demonstrated efficacy for the sorts of children and youth referred for mental health services are the services that are least available in most communities.

To understand this conclusion, it is necessary to know about the epidemiology of child mental health problems and the organization of children's services. Most children and youth with persistent and pervasive mental health problems have behavior disorders, not classical "mental illnesses." Even in cases of depression, the incidence of which rises sharply in adolescence, troubling antisocial behavior rather than troubling feelings commonly leads to the referral of children and youth for evaluation and treatment. Moreover, adults with serious mental disorders generally showed significant symptoms as children and youth, but psychotic adults usually were conduct-disordered children and adolescents.

Thus, although severe behavior disorders in childhood are serious disorders of mental health, responsibility for preventing and treating such conditions is widely diffused. A patchwork of child treatment services (and financing for them) has developed in an unplanned fashion. Essentially the same population is served by the child mental health system, the juvenile justice system, the child welfare system, and the special education system (programs for severely emotionally disturbed pupils). All of these systems provide essentially the same services, especially on a residential or inpatient basis. Private treatment programs frequently receive funds from all four systems. The result is that decreased funding or increased regulation in one system merely pushes children into another residential treatment system. Especially given the incentives that private insurors and Medicaid provide for residential treatment, the easiest, if not the best, way to obtain financing of services to troubling youth from troubled families is to remove them from their homes.

Unfortunately, the changing organization of health care is intensifying this misdistribution of available funds for child mental health services.

My student Mario Scalora and I recently completed a study of certificate-of-need applications for child mental health and substance abuse programs. This study documented what is obvious to the most casual observers of child mental health services. The rate of applications for certificates of need by for-profit hospital corporations is simply explosive, and most states have neither the means nor, in some cases, the authority to determine whether investment is psychiatric hospitals for children is in the public interest. The rate of psychiatric hospitalization among children and youth is rising much faster than among adults, in part because of the diverse sorts of public payment for residential treatment of minors. At the same time, slick and questionably ethical advertising is creating new "markets" for child mental health and substance abuse programs.[2]

Beyond the unnecessary restrictiveness, intrusiveness, and expense stimulated by the funds that are available for inpatient treatment but not for "alternative" treatments, the cost-efficiency of the current system of financing is poor. Not a single controlled study has shown inpatient treatment to be superior to less restrictive treatments for children and youth.

In contrast to the liberal inpatient mental health benefits in many insurance plans, both Medicaid and private insurors generally place unrealistically low "caps" on outpatient mental health services for children and youth.[3] This problem is of concern, because the efficacy of outpatient psychotherapy is demonstrated for children with circumscribed mental health problems (e.g., specific phobias) or self-perceived disturbance (i.e., children who are troubled and would seek help if it were available). Particularly for the latter group, though, the problem may be more one of organization than of financing of services. In that regard, we support efforts to increase children's access to mental health services through school health clinics (which must, of course, be publicly financed) and provisions for minors' consent to services.

For the sorts of children and youth who commonly are referred for services, though, unit-based reimbursement systems that have been adopted from adult health care are ill-suited to child mental health services. When, as is common, youth who are referred have severe family problems, serious deficiencies in academic and vocational skills, and persistent and pervasive conduct problems, it is unrealistic to expect 50 minutes per week of psychotherapy to make a significant difference in their own or their families' lives--a point that outcome research generally supports. Integrated services that respond to the affective, social, and educational/vocational needs of behavior-disordered children and the mental health needs of families in crisis cannot be rendered in an office-based, hour-per-week practice. Simple "coordination" of traditional psychotherapy with social and educational services also is insufficient. Rather, to be maximally effective, treatment must integrate training in problem-solving and mastery of feelings and conflicts with practice in real-life situations and support for families and communities.

Various treatment models--e.g., therapeutic day schools; home-based services; clinical advocacy--have been proven successful in decreasing the troubling behavior of severely disturbed children and youth, increasing their self-esteem, and preserving their families. However, all of these models require availability of therapists as needed (typically, substantially more than 50 minutes per week), a broad therapeutic-educational-social approach, and availability of therapists outside the office in homes, schools, and other settings in which children encounter day-to-day problems. For the most part, third-party payors, particularly those in the health system (both public and private), do not provide reimbursement for such services.

In short, a major problem is that financing for child mental health services is insufficient. However, an equally significant problem is that the financing that is available is used inefficiently. Child mental health professionals are constrained by restrictions on funding from providing the services for which efficacy is best demonstrated and which generally are less expensive than the residential treatments that currently are rewarded. Both psychological theory and research indicate that "alternative" services for severely disturbed children and youth might be better termed "optimal" services. Incentives need to be provided for delivery and evaluation of such programs and disincentives created for programs that result in unnecessary removal of children and youth from their homes and communities.

Although this statement has focused on the children and youth most in need of therapeutic services, the need for financing of preventive mental health services also should be emphasized. Time-and-motion studies in community mental health centers (CMHCs) have shown that prevention never was given great attention in most CMHCs and that the amount of attention given it has shrunk across time as direct federal aid has decreased. The most significant factor in this neglect of preventive services is obvious: prevention does not pay in a unit-based, fee-for-service, illness-based system of financing.

This point should not be lost, because it has become fashionable in some quarters to argue that the lack of attention to prevention is the natural result of a lack of efficacy. Although we recognize that some programs have not been well conceptualized, a conclusion that prevention is doomed simply does not square with outcome research. In fact, some child mental health prevention programs have substantially better documented efficacy--in terms of both absolute outcomes and cost-effectiveness--than most common therapeutic programs. Literally scores of studies have shown remarkable effectiveness of "secondary" prevention programs (i.e., programs designed to prevent major mental health problems in children identified as beginning to show some disturbance), often based in schools and relying on paraprofessionals trained and supervised by mental health professionals.

"Primary" prevention programs (i.e., programs designed to prevent mental health problems from occurring at all) and projects intended simply to promote the mental health of children have been less extensively studied. However, substantial bodies of research have developed about the situations that precipitate mental health problems and the "co-factors" that dampen or exacerbate stress in children. Some points in the development of children (e.g., transition to junior high; repeated hospitalization) and families (e.g., divorce) are known to be high-risk situations amenable to preventive strategies.

Thus, the need to move away from unit-based, fee-for-service models is demonstrated not only by the disincentives that the current system creates for integrated services to severely disturbed children and youth. The current system of financing also chills the development of preventive mental health services that ultimately would result in decreased suffering and loss of economic and social productivity.

To summarize, APA strongly supports initiatives designed to increase the availability of a continuum of mental health services to children, youth, and families. We recognize that underfinancing and inefficient, flawed financing have contributed to the underdevelopment of such services. In addition to increases in funds for "alternative" and preventive services, we would support funding for demonstration projects, with substantial evaluation components, to determine the effects of various potential systems for financing child mental health services.

FOOTNOTES

1. Although they have relatively small budgets, CASSP and the Alcohol, Drug Abuse, and Mental Health block grant set-aside have had important symbolic effects and have stimulated more planful approaches by states to child mental health services. We strongly urge continuation and expansion of such programs.

2. A resolution condemning this practice has been enacted by the APA Division of Child, Youth, and Family Services, the APA Division of Psychologists in Public Service, and the APA Committee on Children, Youth and Families. A copy of the resolution is appended to this statement.

3. We are mindful also of the substantial drop in the proportion of children covered by private health insurance at all. We also are concerned about insurance plans that are unduly restrictive of the range of mental health professionals who may provide services.

DIVISION OF CHILD.
YOUTH. and FAMILY SERVICES
Division 37 of the
AMERICAN PSYCHOLOGICAL ASSOCIATION

RESOLUTION ON ADVERTISING BY PRIVATE HOSPITALS

The Division of Child, Youth, and Family Services of the American Psychological Association expresses grave concern about the strategies of some private hospitals and other residential treatment programs in "marketing" their child and adolescent inpatient programs to the general public. Sensationalist advertising about teenage suicide and parent-child conflicts, for example, may foster unwarranted fear in parents and youth. It also may exacerbate the stigma attached to mental disorders of childhood and adolescence and the negative stereotypes sometimes associated with adolescence itself. Aggressive marketing of inpatient services without attention to alternative forms of service may lead parents and youth into unnecessarily restrictive and intrusive care. "Scare" advertising is an unfair and deceptive practice which is expressly forbidden by the Ethical Principles of Psychologists. Advertising which fails to illuminate choices is also misleading and inconsistent with the promotion of prospective clients' autonomy and, therefore, the spirit of the Ethical Principles.

As proprietary health services develop, the diminished public regulation of services heightens the significance of professional self-regulation. Individual psychologists and the profession as a whole have a weighty obligation to guard the interests of clients and prospective clients. We urge psychologists employed in private residential treatment facilities to exercise appropriate professional and ethical scrutiny of the facilities' policies regarding advertising and client rights. We call upon the APA Ethics Committee and the APA Committee on Children, Youth, and Families to consider ways of responding to the ethical issues raised by privatization of children's services.

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Adopted by the executive committee
February 16, 1986

A SYSTEM OF CARE
FOR SEVERELY EMOTIONALLY DISTURBED CHILDREN & YOUTH

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EXECUTIVE SUMMARY

In her book Unclaimed Children, Knitzer (1982) reported that two-thirds of all severely emotionally disturbed children and youth do not receive the services they need. Many others receive inappropriate, often excessively restrictive care. Recently, there has been increasing activity to improve services for severely emotionally disturbed children and adolescents. The National Institute of Mental Health (NIMH) launched the Child and Adolescent Service System Program (CASSP) to assist states and communities to develop comprehensive, community-based systems of care, and coalitions of policymakers, providers, parents and advocates are being forged to promote the development of such systems of care.

This monograph explores the development of comprehensive systems of care for severely emotionally disturbed children and adolescents. The preparation of the monograph was sponsored by CASSP, and the document represents the final product of a collaborative process undertaken by the CASSP Technical Assistance Center at Georgetown University and the Florida Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children at the Florida Mental Health Institute.

The monograph is intended as a technical assistance tool for states and communities interested in improving services for emotionally disturbed children, and as a review of the state of the art for developing systems of care. A generic model of a system of care is presented along with principles for service delivery and alternative system management approaches. This model offers a conceptual framework to provide direction to policymakers, planners and providers. It is expected that states and communities will modify and adapt the model to their particular environments, and will establish priorities for system development in accordance with their needs.

BACKGROUND

The Joint Commission on the Mental Health of Children (1969) found that millions of children and youth were not receiving needed mental health services. Many of the children that were served received inappropriate, unnecessarily restrictive care, often in state mental hospitals. The President's Commission on Mental Health (1978) echoed the Joint Commission's conclusions, finding that few communities provided the volume or continuum of programs necessary to meet children's mental health needs. Both Commissions recommended that an integrated network of services be developed in communities to meet the needs of severely emotionally disturbed children and youth. Knitzer (1982) asserted that the needs of severely emotionally disturbed children have remained largely unaddressed. She considers these children to be "unclaimed" by the public agencies with responsibility to serve them.

These reports and others have made it apparent that the range of mental health and other services needed by severely emotionally disturbed children and adolescents is frequently unavailable. Many children are institutionalized when less restrictive, community-based services would be more effective. Additionally, there have been few attempts to get mental health, child welfare, juvenile justice, health and education agencies to work together on behalf of disturbed children and youth. This has left children and youth with serious and complex problems to receive services in an uncoordinated and piecemeal fashion, if at all.

Currently, there is broad agreement about the critical need to improve both the range and coordination of services delivered to severely emotionally disturbed children and their families. The development of comprehensive, coordinated "systems of care" for children and youth has become a national goal.

The term "continuum of care" has been used extensively in the field to describe the range of services needed by severely emotionally disturbed children and adolescents. In fact, much of the published literature and many of the materials produced by states use this term. Throughout this document, the term "system of care" is employed. Before proceeding to describe the system itself, definitions of these terms are required, along with the rationale for using the latter term.

"Continuum of care" generally connotes a range of services or program components at varying levels of intensity. These are the actual program elements and services needed by children and youth. "System of care" has a broader connotation. It not only includes the program and service components, but also encompasses mechanisms, arrangements, structures or processes to insure that the services are provided in a coordinated, cohesive manner. Thus, the system of care is greater than the continuum, containing the components and provisions for service coordination and integration.

A system of care, therefore, is defined as follows:

> **A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents.**

This monograph describes how these systems of care might look and how they might be organized.

SEVERELY EMOTIONALLY DISTURBED CHILDREN AND THEIR NEEDS

The Federal CASSP initiative is focused on severely emotionally disturbed youngsters whose problems are so severe as to require the long-term intervention of mental health and other agencies. To assist states and communities in identifying this population, NIMH developed a set of basic parameters for defining the target population (Stroul, 1983).

As these parameters indicate, the designation of "severe emotional disturbance" among children should be primarily based on functional disabilities which are of significant severity and duration, and on the need for a broad range of services. This set of general criteria is designed to guide the system building efforts of states, while allowing states the flexibility to develop more specific definitions. Several states have developed such definitions.

The prevalence of severe emotional disturbance among children and youth is difficult to determine. The primary reasons for this are the lack of agreement about the definition of "severe emotional disturbance," the difficulty in measuring the socio-emotional disturbances, and the great cost and practical obstacles in conducting epidemiological research in children's mental health.

Based on a review of a number of epidemiological studies, Gould, Wunsch-Hitzig & Dohrewend (1981) estimated that the prevalence of "clinical maladjustment" among children is at least 11.8 percent. Despite methodological inconsistencies and deficiencies in the research, the estimate by Gould et al. of 11.8 percent appears to be a reasonable, if not somewhat conservative, estimate.

A subset of this group of children showing emotional problems can be considered severely emotionally disturbed. From a review of existing prevalence research, Knitzer (1982) concluded that a conservative estimate of serious emotional disturbance in children is five percent or approximately three million youngsters. In the description of CASSP, NIMH (1983) has adopted the same figure. While this figure is not firmly based empirically, it appears to be generally consistent with the research and reasonable as an estimate. It should be kept in mind that this five percent estimate includes only youngsters whose problems are severe and persistent, while the 11.8 percent estimate includes all emotionally disturbed youngsters.

While differences around definition and prevalence may persist, there is greater consensus about the needs of severely emotionally disturbed children. These children require a range of mental health services which are age appropriate and at varying levels of intensity. However, mental health services alone are not enough. Emotionally disturbed children almost universally manifest problems in many spheres including home, school and community. As a result, they require the intervention of other agencies and systems to provide special education, child welfare, health, vocational and, often, juvenile justice services.

Thus, the needs of severely emotionally disturbed children and youth cannot be met by the mental health system in isolation. A comprehensive array of mental health and other services are required to meet their needs. The conclusions of nearly all commissions and experts converge in recommending a multiagency, multidisciplinary system of services for emotionally disturbed children and their families.

Although comprehensive systems of care for emotionally disturbed children have been recommended for some time, progress in developing such systems has been slow. At present, there are serious gaps both in terms of the mental health services that are available to children and their families and the other essential services. Where such gaps in actual service do not exist, the lack of coordination between agencies seriously limits the effectiveness of individual service components. The consequence of these system deficiencies is that treatment is often inadequate and fragmented.

The situation is complicated by an overreliance on more expensive and more restrictive services than are actually needed. Behar (1984) reports a strong tendency to remove children from their families and natural environments with the belief that effective treatment can only be accomplished in a residential setting. Knitzer (1982) identified efforts to increase residential care in almost half of the states, while nonresidential services remained either nonexistent or rudimentary. Thus, residential services appear to be overutilized, although recent experience indicates that intensive services in the home and school may reduce the need for residential care (Friedman and Street, 1985). When residential care is indicated, less restrictive, community-based alternatives such as therapeutic foster care are often neglected in favor of institutionally-based services.

While these problems remain, there are indications of progress in services for severely emotionally disturbed children. The need for comprehensive, community-based systems of service that incorporate a wide range of different services is receiving more and more recognition. Isaacs (1983, 1984) found that a number of states have identified children's mental health as one of their top mental health priorities, and many states are now initiating system development activities. Nearly half the states in the nation are now involved in the CASSP initiative, and both funded and unfunded states are participating in technical assistance activities related to system of care development such as regional and national conferences. It seems clear that interest in developing comprehensive systems of care has increased markedly.

PRINCIPLES FOR THE SYSTEM OF CARE

The system of care for severely emotionally disturbed children and adolescents represents more than a network of service components. Rather, the system of care represents a **philosophy** about the way in which services should be delivered to children and their families. The actual components and organizational configuration of the system of care may differ from state to state and from community to community. Despite such differences, the system of care should be guided by a set of basic values and operational philosophies.

Not surprisingly, there is general agreement in the field and in the literature as to the values and philosophy which should be embodied in the system of care for severely emotionally disturbed youth. With extensive consultation from the field, two core values and a set of 10 principles have been developed to provide a philosophical framework for the system of care model.

The two core values are central to the system of care and its operation. The first value is that the system of care must be driven by the needs of the child and his or her family. In other words, the system of care must be **child-centered**, with the needs of the child and family dictating the types and mix of services provided. This child-centered focus is seen as a commitment to adapt services to the child and family, rather than expecting children and families to conform to pre-existing service configurations. It is also seen as a commitment to providing services in an environment and a manner that enhances the personal dignity of children and families, respects their wishes and individual goals, and maximizes opportunities for involvement and self-determination in the planning and delivery of services.

The second core value holds that the system of care for emotionally disturbed children should be **community-based**. Historically, services for this population have been limited to state hospitals, training schools and other restrictive institutional facilities. There has been increasing interest and progress in serving such children in community-based programs which provide less restrictive, more normative environments. The system of care embraces the philosophy of a community-based network of services for emotionally disturbed youth and families. While "institutional" care may be indicated for certain children at various points in time, in many cases appropriate services can be provided in other, less restrictive settings within or close to the child's home community.

In addition to these two fundamental values for the system of care, 10 principles have been identified which enunciate other basic beliefs about the optimal nature of the system of care. The values and principles are displayed on the following page, and each principle is discussed within the monograph.

SYSTEM OF CARE FRAMEWORK AND COMPONENTS

The system of care model presented in this document represents one approach to a system of care. No single approach has as yet been adequately implemented and tested to be considered the ideal model. The model presented is designed to be a

CORE VALUES FOR THE SYSTEM OF CARE

1. The system of care should be child-centered, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

GUIDING PRINCIPLES FOR THE SYSTEM OF CARE

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.

2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.

3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.

5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.

6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.

7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.

9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.

10. Emotionally disturbed children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

guide, based on the best available empirical data and clinical experience to date. It is offered as a starting point for states and communities as they seek to build their systems, as a baseline from which changes can be made as additional research, experience and innovation dictate.

While individuals may wish to examine the services in their own states and communities in relation to the system presented here, the information is not intended to be used as a checklist. The desired system in a particular community is dependent, in part, upon community characteristics such as population, physical size, proximity to other communities, unique resources and special features of the population. Not every community is expected to have every service in place. The model is not a prescription, but rather should serve as a guide for communities, with the expectation that it will be modified and adapted to meet special conditions and needs.

States and communities are also expected to establish different system development priorities. An approach frequently used involves defining a core or minimal set of services as the first priority for system of care development efforts. When goals in relation to this core set of services are achieved, states and communities may then begin to develop an expanded array of service options.

The system of care model is organized in a framework consisting of seven major dimensions of service, each dimension representing an area of need for children and their families. The framework is graphically presented on page ix, and includes the following dimensions:

1. Mental health services

2. Social services

3. Educational services

4. Health services

5. Vocational services

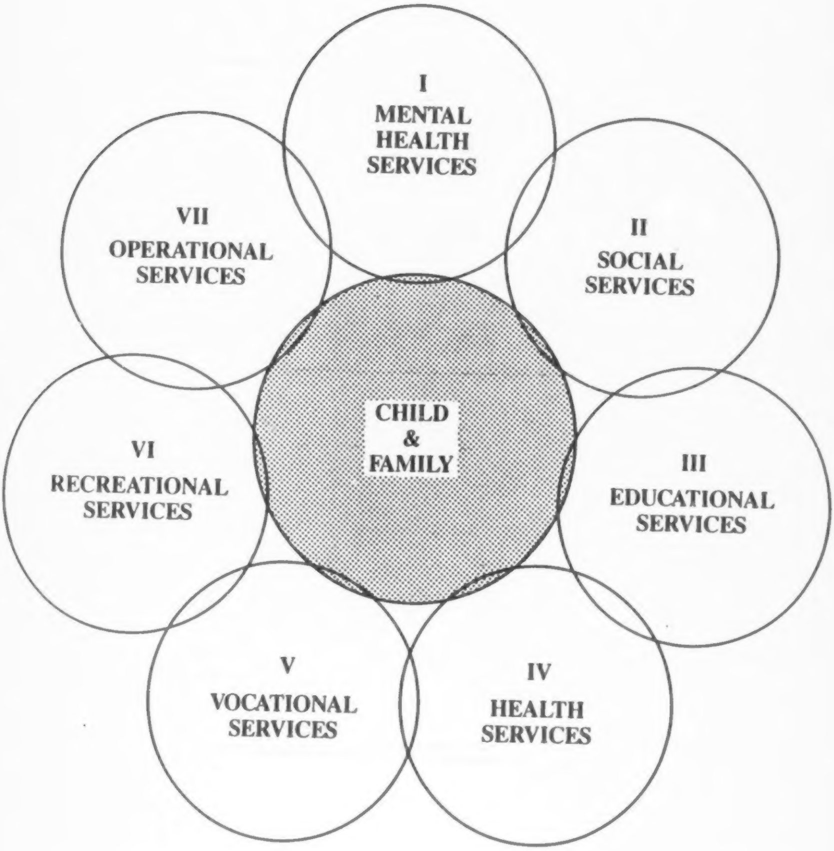
6. Recreational services

7. Operational services

The system of care model is intended to be function-specific rather than agency-specific. Each service dimension addresses an area of need for children and families, a set of functions that must be fulfilled in order to provide comprehensive services to meet these needs. The model is not intended to specify which type of agency should fulfill any of the particular functions or needs. Certainly, particular agencies typically provide certain of these services in communities. Educational services, for example, are most often provided by school systems, and social services are generally associated with child welfare or social welfare agencies. One might assume that the mental health services should be provided by mental health agencies. This, however, is often not the case.

All of the functions included in the system of care dimensions may be fulfilled by a variety of agencies or practitioners in both the public and private sectors. Therapeutic group care, a component in the mental health dimension, is often fulfilled by juvenile justice agencies and social service agencies as well as by mental health

SYSTEM OF CARE FRAMEWORK



agencies. Day treatment is another mental health function that is frequently fulfilled by the educational agencies, ideally in close collaboration with mental health providers.

While the roles and responsibilities of specific agencies are acknowledged, an effective system of care should be based on child and family needs primarily, rather than on agency features. Many of the services to be described can be, and are, provided by different agencies in different communities.

Furthermore, many of these services are provided not through the efforts of any single agency but through multiagency collaborative efforts. Such collaborations are important not only in identifying needs and planning services but also in developing, funding and operating services.

It should also be recognized that services are not always provided by agencies. Some functions within the system of care may be fulfilled by families, parent cooperatives or other such arrangements. Private sector facilities and practitioners can also play a pivotal role in the system of care, providing a wide range of services within each of the major dimensions.

Juvenile justice agencies play an important role in the system of care. The juvenile justice system provides a wide range of services to children and adolescents who have broken the law. While the juvenile justice system has an interest in helping children and families, its mission is also to meet the needs of the community and society. This mission is accomplished through measures to control troublesome or delinquent behavior (Shore, 1985). Many juvenile offenders can be considered emotionally disturbed, and the juvenile justice system plays a critical role in serving emotionally disturbed juvenile offenders. Juvenile justice agencies provide or collaborate with other agencies to offer many of the system of care components to this subgroup. Among the components frequently provided by juvenile justice agencies are outpatient services, therapeutic foster and group care and residential treatment. The critical role of the juvenile justice system in serving emotionally disturbed juvenile offenders must be acknowledged as well as its special role in the system of care.

An important aspect of the concept of a system of care is the notion that all components of the system are interrelated, and that the effectiveness of any one component is related to the availability and effectiveness of all other components. For example, the same day treatment service may be more effective if embedded in a system that also includes good outpatient, crisis and residential treatment, than if placed in a system where the other services are lacking. Similarly, such a program will be more effective if social, health, and vocational services are also available in the community than if they are absent or of low quality. In a system of care, all of the components are interdependent--not only the components within a service dimension such as mental health, but all of the seven service dimensions that comprise the model.

A critical characteristic of an effective system is an appropriate balance between the components, particularly between the more restrictive and less restrictive services. If such balance is not present, then youngsters and families will not have a full chance to receive less restrictive services before moving to more restrictive services. If, for example, within a community there are no intensive home-based services, only 20 day treatment slots and 50 residential treatment slots, the system is not in balance. Youngsters and families will most likely not have the opportunity to participate in home-based or day treatment services because of their relative unavailability, and the residential components of the system will be overloaded with youngsters, some of whom might have been diverted from residential treatment if there had been more nonresidential services available.

At the present time there are no clear, empirically-based guidelines about the appropriate capacity within each component of a system of care. As a consequence, no specific quantitative guidelines are presented in this document. Implicit within a model system of service, however, is the expectation that more youngsters will require the less restrictive services than the more restrictive ones, and that service capacity should, therefore, diminish as one proceeds through the system. In particular, the system capacity in the more intensive of the nonresidential services should exceed the system capacity in the residential service components. As additional research and field experience are accumulated with respect to systems of care for severely emotionally disturbed children, it may become possible to define the optimal ratios of capacities in the different system components.

Within each of the seven service dimensions is a continuum of service components. These dimensions and the components within them are displayed on the following page, and are described within the monograph. The major focus, however, is on the continuum of mental health services since these are critical services for all severely emotionally disturbed children. While the mental health dimension is described in some detail, brief descriptions are provided with respect to the other dimensions. These descriptions are intended as introductions to the service dimensions, and not as comprehensive reports on all the services included in the system of care.

Throughout the discussion of the individual services, it should be recalled that these are component parts of an overall system of care. The boundaries between the various dimensions and components are not always clear, and frequently there is overlap among them. While they are described individually, the system of care dimensions and service components cannot be operated in isolation. Only when the services are enmeshed in a coherent, well-coordinated system will the needs of severely emotionally disturbed youngsters and their families be met in an appropriate and effective manner.

The mental health services of the system of care are shown on page xiii. They are divided into seven nonresidential categories, and seven residential categories. The components often overlap to some degree. For example, the difference between therapeutic group care and residential treatment is not always clearly distinguishable. Further, there are a variety of different program models for each component, such as several distinct approaches to therapeutic foster care. Some of these different models are noted in the discussion of the components in the monograph.

The operational services dimension is somewhat different from the other system of care dimensions. This dimension includes a range of support services that can make the difference between an effective and an ineffective system of care, but do not fall into a specific category. Instead, they tend to cross the boundaries between different types of services. They are called "operational services" because of their importance to the overall effective operation of the system. The services included in this dimension are case management, self-help and support groups, advocacy, transportation, legal services and volunteer programs.

Case management is an essential service that can play a critical role in the system of care. Behar (1985) calls case management "perhaps the most essential unifying factor in service delivery." This indicates the important role that case management can play

COMPONENTS OF THE SYSTEM OF CARE

1. MENTAL HEALTH SERVICES

- Prevention
- Early Identification & Intervention
- Assessment
- Outpatient Treatment
- Home-Based Services
- Day Treatment
- Emergency Services
- Therapeutic Foster Care
- Therapeutic Group Care
- Therapeutic Camp Services
- Independent Living Services
- Residential Treatment Services
- Crisis Residential Services
- Inpatient Hospitalization

2. SOCIAL SERVICES

- Protective Services
- Financial Assistance
- Home Aid Services
- Respite Care
- Shelter Services
- Foster Care
- Adoption

3. EDUCATIONAL SERVICES

- Assessment & Planning
- Resource Rooms
- Self-Contained Special Education
- Special Schools
- Home-Bound Instruction
- Residential Schools
- Alternative Programs

4. HEALTH SERVICES

- Health Education & Prevention
- Screening & Assessment
- Primary Care
- Acute Care
- Long-Term Care

5. VOCATIONAL SERVICES

- Career Education
- Vocational Assessment
- Job Survival Skills Training
- Vocational Skills Training
- Work Experiences
- Job Finding, Placement & Retention Services
- Sheltered Employment

6. RECREATIONAL SERVICES

- Relationships with Significant Others
- After School Programs
- Summer Camps
- Special Recreational Projects

7. OPERATIONAL SERVICES

- Case Management
- Self-Help & Support Groups
- Advocacy
- Transportation
- Legal Services
- Volunteer Programs

DIMENSION I: MENTAL HEALTH SERVICES

NONRESIDENTIAL SERVICES:

PREVENTION

EARLY IDENTIFICATION & INTERVENTION

ASSESSMENT

OUTPATIENT TREATMENT

HOME-BASED SERVICES

DAY TREATMENT

EMERGENCY SERVICES

RESIDENTIAL SERVICES:

THERAPEUTIC FOSTER CARE

THERAPEUTIC GROUP CARE

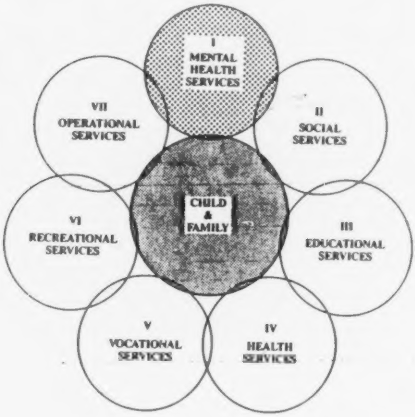
THERAPEUTIC CAMP SERVICES

INDEPENDENT LIVING SERVICES

RESIDENTIAL TREATMENT SERVICES

CRISIS RESIDENTIAL SERVICES

INPATIENT HOSPITALIZATION



in a system of service, a role that has been increasingly recognized in recent years but has only been operationalized in a few states.

Case management serves youngsters involved in both residential and nonresidential programs. It involves brokering services for individual youngsters, advocacy on their behalf, insuring that an adequate treatment plan is developed and is being implemented, reviewing client progress and coordinating services. Case management involves aggressive outreach to the child and family, and working with them and with numerous community agencies and resources to ensure that all needed services and supports are in place.

Advocacy can also play a critical role in the system of care. There are two basic types of advocacy. The first is "case" advocacy, or advocacy on behalf of the needs of individual children. Effective case advocates must be knowledgeable about the workings of the service systems which serve children, and must be skilled in making these systems more responsive to the needs of individual children. Case managers perform case advocacy functions, but other professionals, citizen advocates and parents can fulfill this role as well.

The second type of advocacy is "class" advocacy, or advocacy on behalf of a group of individuals. Class advocacy, if successful, can have a greater impact than case advocacy because it can produce changes that affect more children (Knitzer, 1984). Class advocacy is typically a lengthy process that requires not only considerable knowledge and skill, but also enormous persistence.

Efforts to advocate for improved services are beginning to take the form of coalitions of parent, provider, professional and voluntary advocacy organizations. These coalitions are forming at community, state and national levels, and have potential for exercising considerable influence over policies and services.

The increased interest in advocacy is one of the more encouraging signs in the children's mental health field in recent years. A key issue affecting the degree to which effective systems of care will be developed is the extent to which strong, persistent and well-targeted advocacy efforts can be developed at the community, state and national levels.

MANAGEMENT OF THE SYSTEM OF CARE

The development of strong components is undoubtedly the most important aspect of developing an effective system. Another important aspect, however, is insuring that the system is managed in a clear and consistent way to assure that youngsters and families receive the services they need in a coherent and coordinated manner.

Proper system management should insure good coordination between components of the system. Such coordination is necessary because most youngsters require services from more than one component at a particular point in time. Only in a well-managed system would it be possible for one youngster to receive all of these needed services, and particularly to receive them in a manner that produces coordinated efforts by different professionals and agencies to achieve the same goals. Effective system management should also insure that as a child's needs change, he or she will be able to easily move into different services, or that existing services will adapt to the new needs.

A major issue with respect to system management is the relationship between state level and community level agencies in managing the system. This includes such questions as the extent to which fiscal resources are controlled at the state level or community level, the degree of flexibility that communities are allowed to develop systems tailored to meet the specific needs within their area, and the degree to which decision making takes place at the community level versus the state level.

In order for the system to be able to be most responsive to the needs of the child and family, the community should most logically be responsible for system management and coordination. However, the state must also play a major role in systems of care. The role of the state in relation to the community should be to share in providing resources for the system, to establish standards for communities to meet in developing services, to monitor and evaluate the performance of communities, to establish policies and procedures to facilitate effective service delivery, and to provide consultation and technical assistance to help communities. States may also provide certain limited services that are best provided at a regional or state level, either because they are extremely specialized or deal with problems too low in prevalence to support community level efforts. Overall, the role of the state should be to promote the development of strong and effective community-based systems of services.

Within an overall framework of community-based system management of the system of care, there are three basic approaches that can be taken. These approaches include management by a consolidated agency, management by a lead agency, or management by multiple agencies through formal agreements. Each approach is described within the monograph.

Case management plays a critical role in all three system management approaches. Case managers are the "glue" which holds the system together, assuring continuity of services for the child and family. Whether a consolidated agency, lead agency or multiagency management model is used, case managers see to it that the various service components are coordinated and that service needs are assessed and reassessed over time.

Some states and communities have been experimenting with case review committees as an additional management structure (Friedman, 1985). Such committees are used to make or review decisions about appropriate treatment or placement for youngsters in order to insure that the rights of children are protected and that decisions are in the child's best interests.

Several points with respect to system management appear to be important, although they have not yet been empirically tested. It seems essential that, whatever management approach is selected, it should be community-based. Trying to manage a direct service system for youngsters in communities across a state from a state office is cumbersome and inefficient. Further, centralized state level management does not create a sense of commitment in communities for accepting responsibility for serving their children.

It also seems clear, and is a consistent theme of this monograph, that whatever approach is taken must involve the close cooperation of agencies including the mental health, health, social service, juvenile justice agencies and the school system. Such cooperation is needed both for developing and implementing the component parts of the system and for management of the overall system.

Finally, there are increasing indications that case managers are a key component of any attempt to make a system truly responsive to the needs of the individuals it is designed to serve. For a system to be effectively operated, there should be case managers who can pull services together from a variety of sources to meet the needs of individual clients.

STRATEGIES FOR DEVELOPING SYSTEMS OF CARE

Conceptualizing a system of care model is only a preliminary step in the system improvement process. The real challenge for states and communities is to transform their system of care plans into reality. The monograph outlines a number of specific strategies and approaches that might be used to translate plans into functioning networks of services for severely emotionally disturbed children and their families.

System change strategies are defined broadly as planned actions that the mental health agency can take, in collaboration with other appropriate organizations and groups, to promote the development of systems of care for severely emotionally disturbed children and youth (Stroul, 1985).

Each state or community involved in a system development initiative will select system change strategies that are most appropriate for its particular environment and circumstances. Nevertheless, the experience of other system change programs suggests the types of strategies which are most likely to have a broad impact. These system change activities fall within six major areas including:

- Planning and needs assessment,
- Modifying the mental health system,
- Interagency collaboration,
- Technical assistance and training,
- Constituency building, and
- Local system development.

It should be noted that these categories represent not alternative strategies, but rather complementary strategies. In order to develop effective systems of care, states and communities should be selecting and implementing strategies from each of these categories, varying the emphases, strategy types and sequencing to conform with the particular environment.

Within each category, there are innumerable strategies that states or communities may select. A discussion of the strategies within each broad area is included in the monograph.

SYSTEM ASSESSMENT

This monograph has been prepared to assist states and communities to improve services for severely emotionally disturbed children and adolescents. In general, despite significant deficiencies in the present service systems in many states, there is much to be encouraged about. There has been increased attention paid to the needs of emotionally disturbed children and their families. In particular, there is growing recognition that effective service systems require a range of services and close interagency collaboration. Important progress is being made in developing new service components and in providing case management services to link the various services. Additionally, there is an expanding knowledge base about effective community-based service options, system management and strategies for producing system change.

The monograph concludes by presenting a series of questions to assess systems of care on a statewide or community basis. The assessment questions address the characteristics of an effective system with respect to such areas as the development of a model, planning and decision making processes and interagency relationships. The questions are by no means exhaustive; many additional questions and characteristics may be relevant to assessing systems of care.

The assessment questions are followed by sample worksheets for assessing the status of the development of the various system of care components. The assessment questions and worksheets are presented to summarize the information presented in the monograph and to provide readers with a framework for evaluating the status of the system in their state and community.

The monograph is intended to provide states and communities with a conceptual model for a system of care for severely emotionally disturbed children and youth. The model can be used as a guide in planning and policymaking, and provides a framework for assessing present services and planning improvements. The model can be conceptualized as a blueprint for a system of care which establishes directions and goals.

This model should not be seen as the only way to conceptualize systems of care. States and communities may revise and adapt the model to conform with their needs, environments and service systems, or they may develop a distinctly different system of care configuration. The model must also be regarded as flexible, with room for additions and revisions as experience and changing circumstances dictate.

Most important is the acknowledgement that conceptualizing a system of care represents only a **preliminary step** in the service system improvement process. Development of a system of care model is a planning task which must be followed by implementation activities including necessary state level arrangements and local program development efforts. While designing a system of care is an essential and challenging task, the real challenge for states and communities is to transform their system of care plans into reality.

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July 14, 1987

Statement for the Record
Select Committee on Children, Youth and Families
Hearing on Children's Mental Health: Promising Responses to Neglected Problems

The American Academy of Child and Adolescent Psychiatry is pleased to be able to submit this statement for the record regarding "Children's Mental Health: Promising Responses to Neglected Problems.

INTRODUCTION

The American Academy of Child and Adolescent Psychiatry is a membership organization of child and adolescent psychiatrists, all of whom are physicians with subspecialty training engaged in the understanding, diagnosis and treatment of psychiatric and emotional disorders in children and adolescents. It is the only professional specialty to limit its concerns to child and adolescent mental illness. With 3700 members located in each of the fifty states, the Academy works within large and small communities. Its members work with families, guardians, educators, public servants and private organizations, juvenile justice officers, and others who have contact with children and adolescents with emotional disturbances.

The Academy agrees with the failures that have been cited in recent national examinations of the mental health system's accountability toward children, including the following:

- Critical shortages exist in professionals trained to treat children and adolescents with serious emotional illnesses which creates a burden for service delivery systems. This has repercussions and adds stressors to all service delivery systems, but particularly public programs. It is child psychiatrists who are trained to treat these seriously ill children and adolescents.

- Research in children's mental illnesses lags behind other mental and physical illness research; longitudinal research which is the most necessary and promising is all but non-existent.

- States have not had the encouragement or resources to coordinate agencies and provide technical assistance for recognizing, evaluating and treating children and adolescents who are at risk for or who are seriously emotionally disturbed. The Child and Adolescent Service System Program (CASSP) is a promising response to this problem, but it is constantly in jeopary of losing funding;

- Prevention programs and longitudinal studies have not been effectively developed or financed.

Child and adolescent psychiatrists, identified by a Department of Health and Human Services report as the most underserved medical specialy, daily witnesss the unmet needs of the children and adolescents in their communities. Recently, a member of the Academy, Dr. Murray Persky, wrote that, "Adult care is, to some extent, blessed with a continuum of care from acute to subacute and chronic but this system is not in place for children." He notes that in the California Bay Area, children with serious emotional disturbances, "have been 'farmed' out to Sacramento, Vallejo, juvenile halls, emergency rooms, adult wards, crisis units, Children's Home Society and many more distant and unlikely places." Child psychiatrists treat serious and chronically ill children and adolescents, and they are unified in their belief that, although children seldom need hospitalization, when they do, it is critical that appropriate hospital care been given, and coordinated aftercare support systems be available. No community should have to rely solely on one form of care, such as hospitalization.

AREAS OF RESPONSE

In responding to these areas of need within the children's mental health system, the Academy has planned and developed special projects that allow its members to work for improved training, prevention, treatment and continuum of services not only at their local level but as a national campaign.

The American Academy of Child and Adolescent Psychiatry is contributing to the "promising responses" directed toward the neglected problems of children's mental health. As part of a two-year project, the Academy is currently leading prevention projects in the following areas:

- To examine the risk factors and prevention of conduct disorders. Children with conduct disorders have been noted to be the largest single group of emotionally disturbed children treated or untreated, and attempts to treat them have not always been successful. Early identification of particularly dangerous couplings of symptoms may allow focused intervention of increasingly scarce resources.

- To understand the risk factors and intervention strategies that would lead to the prevention of substance abuse, specifically in children and adolescents. By analyzing the effectiveness of affective and interpersonal education programs; behavioral prevention programs; community-based family-focused prevention interventions; and other innovative programs, substance abuse may be better understood and controlled.

- To respond to the tragic and all too often unexplainable reason that children and adolescents take their own lives. The effort to understand and prevent suicide by the young has been gathering data for some time, and the warning signs of suicide are now known. But the intervention strategies are not so well known and are being studied.
- To prevent learning disorders. The biological, psychological, social and educational factors of learning disabilities are being examined with the hope of breaking the causal chain.
- To research the linkage between parental mental disorder as a psychiatric risk factor for children. This is an ongoing project of Academy members, and a special focus at this time.
- To examine, as part of the current effort to understand the prevention of childhood psychiatric illnesses, two additional areas: Understanding how to prevent psychiatric illness in young victims of inadvertent trauma, and how chronic physical illness is a risk factor for psychiatric disorder.

If the understanding of how to prevent mental illness in children is moved forward in each of these areas, the Academy's two year focus will be successful. The research will be disseminated to the child psychiatry training programs as well as shared with other mental health professionals. The Academy would recommend that federal support for research into child and adolescent psychiatric illnesses be increased wherever possible -- within the National Institute of Mental Health, the Maternal and Child Health Program, the National Institutes of Child Health and Human Development, and the Institutes on Drug Abuse and Alcohol and Alcoholism. The special need for longitudinal research into childhood mental illnesses has been emphasized for years. Because of the expense and the need for dedicated long-term researchers, it is recommended that federal support be offered through those same agencies for the purpose of initiating and sustaining longitudinal research.

In addition to the promising responses from a national call for prevention of specific illnesses, Academy members are working on individual research projects designed to develop innovative treatments that fit into a continuum of services, thus shortening inpatient hospital time. Submissions for examination by members and other mental health professionals have focused on finding resources for developing day and partial hospitalization treatment as a strategy to reduce length of stay, as well as using partial hospitalization as an effective early intervention.

Prevention, early intervention, accurate diagnosis and appropriate treatment are primary goals for Academy members. Past research, treatment, education, and public information programs have provided child psychiatrists with knowledge and techniques to treat their patients more effectively. The current projects hold more promise for reducing the number of children and adolescents who will need treatment for serious emotional disturbances.

The Academy appreciates the opportunity to submit this brief statement outlining areas of promising responses to the serious emotional illnesses of childhood and adolescence. Thank you for scheduling this hearing to focus public attention on children's mental health. Please contact the Academy if additional information is needed on any of subjects discussed in the statement or if you have questions about the stated information.

Irving Philips, M.D.
President

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